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ABSTRACT

This curriculum guide contains articles from numerous experts in the field of mental health counseling. This issue includes: (1) "Therapeutic Approaches to Anxiety Disorders" (Robert L. DuPont); (2) "The Role of Nutrition in Detoxification from Drugs and Alcohol" (Jeffrey S. Bland); (3) "'Repair' vs. 'Growth' Approaches to Therapy" (Paul L. Adams); (4) "Marriage and Family Therapy: Theories and Applications" (Stanley C. Feist); (5) "Current Issues in Treating Sexual Abuse Victims" (Robert H. Rencken); (6) "Current Practice and Procedures of Group Psychotherapy" (Martin G. Allen); (7) "Psychotherapy with Dual Diagnosis Clients: Issues and Intervention" (Emil Chiauzzi); (8) "Aggression Replacement Training in Children and Adolescents" (Barry Glick); (9) "Chronic Fatigue Syndrome: Perspectives on Evaluation and Treatment" (Mark A. Demitrack); (10) "Research Findings on Short-Term Psychodynamic Therapy Techniques" (Jeffrey L. Binder); (11) "Geriatric Alcoholism: Identification and Elder-Specific Treatment Programs" (Jane Reinhardt, George Fulop); and (12) "Women at Risk for Committing Suicide" (Lucy Davidson). Each lesson includes a list of references and questions based on the lesson. (BF)

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Directions in Mental Health Counseling

VOLUME 3 • LESSON 1

Therapeutic Approaches to Anxiety Disorders

Robert L. DuPont, MD

Dr. DuPont is President, Institute for Behavior and Health Inc, Rockville, MD,
and Clinical Professor of Psychiatry, Georgetown University School of Medicine, Washington, DC.

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EDITOR'S NOTE

The heart of the psychological therapy of anxiety disorders is cognitive-behavioral therapy, which involves re-education of the clients about the nature of their illnesses and the goals of therapy, as well as active and repeated entry into fear-generating experiences. These treatments view the anxious symptoms as distressing but not dangerous; the illnesses are held to be serious but curable, in the sense that the sufferer's life, which had been made unmanageable by the disorder, can be brought under control.

Therapy is unlikely to be successful without exposure to the anxiety-provoking situation on a routine basis. Thus, cognitive-behavioral therapy involves changing the way anxious people think about their symptoms—and changing their behaviors so that they move toward, rather than away from, the experiences that produce distressing feelings.

Many anxious clients benefit from traditional individual, family, and group psychotherapy. Self-help plays an increasing role in the therapy of anxiety disorders; for some clients, adjunctive therapy techniques, including aerobic exercises and the elimination of caffeine and alcohol intake, are also useful. A variety of other therapies are often helpful as well, including stress management, relaxation training, and assertiveness training.

Introduction

The anxiety disorders have recently joined the affective disorders as another focus of mental health research and practice. Even though much of the new interest centers on pharmacologic treatments, the psychological approach to anxiety disorders remains the foundation of clinical practice. This lesson deals with the psychological therapy of the anxiety disorders as well as with the epidemiology and diagnosis of these disorders.

The Clinically Anxious Client

Although anxiety can be a useful feeling in that it serves as a warning signal of serious internal or external threat, the anxiety disorders are characterized by maladaptive anxiety, which leads to distress and disability. The hallmark of anxiety disorders is worry, which is understood by the client to be unrealistic and excessive (DuPont, 1983; DuPont, 1986). The brain's normal alarm system is triggered inappropriately, leading to unrealistic fear of danger, and often secondarily to loss of self-esteem and depression. Clinically anxious clients are often able to identify a tendency toward excessive worry that dated from childhood and to provide a history of family members who have suffered from similar anxiety disorders.

When talking with anxious clients I use the metaphor that, based on my experience with other clients suffering from similar problems, they have a "worry machine" in their brain that churns out a neverending stream of scary and upsetting "what if" scenarios. These are automatic, involuntary negative thoughts. Clients need to find ways to cope with the worry machine by separating "what is" problems from "what if" fears. I also explain that the anxiety disorder will not lead to psychosis or other mental or physical illness; their anxiety symptoms are distressing, but not dangerous.

Although everyone experiences anxiety from time to time, and while many of the anxiety disorders have echoes in everyday life (such as mild fear of heights, flying, or public speaking), a diagnosis is made only when these anxieties persist and significantly reduce the quality of the client's life. The *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R) (American Psychiatric Association, 1987) contains detailed descriptions of the anxiety disorders. Subsyndromal anxiety conditions may also respond to therapy. **The boundaries between the individual anxiety disorders are not clear-cut: many clients suffer from more than one.** The primary diagnosis is the one that dominates the clinical picture. The pattern of anxious symptoms typically remains reasonably stable even over many years.

Recognition of Anxiety Disorders

The anxiety disorders are now categorized into six major syndromes, although future diagnostic classifications can be expected to lump and split these closely related syndromes in different ways. They are listed below with brief descriptions including their DSM-III-R diagnostic numbers in parentheses.

PANIC DISORDER WITH AGORAPHOBIA AND WITHOUT AGORAPHOBIA:

Panic attacks are sudden, overwhelming feelings of terror, often associated with fear of going crazy, losing control, or dying. They are usually accompanied by physical symptoms including rapid heart rate, trembling, and difficult breathing. When panic attacks come unexpectedly, they are called "spontaneous," and when they come in predictable situations for a particular client (for example, in a shopping center or when driving on a freeway) they are called "situational." Early

in the syndrome, spontaneous panic may predominate, but later in the evolution of the disorder, situational panic often is more frequent; spontaneous panic may even disappear.

Agoraphobia is "adult separation anxiety;" fears are commonly of separation from a safe person or a safe place. Panic attacks can occur without agoraphobia, and agoraphobia can occur without spontaneous panic attacks and sometimes without situational panic attacks.

The sudden flash of panic, with the catastrophic thoughts and sympathetic nervous system discharge, is called the "first fear." The anticipation of this fear, also known as anticipatory anxiety, is called the "second fear." The first fear commonly leads to the second fear, which usually predominates later in the course of the disorder. The second fear is usually followed by avoidance, the source of most of the disability in the disorder. To the extent possible, many sufferers from panic disorder and agoraphobia seek to avoid experiences that will precipitate panic attacks, and, failing this, they seek to avoid situations in which panic attacks may cause danger or embarrassment. These three factors—panic, anticipatory anxiety, and avoidance—are locked together in a single vicious circle.

SIMPLE PHOBIA:

Characterized by intense fear of particular situations or experiences, usually without spontaneous panic attacks and often without prominent autonomic nervous system discharges associated with situational panic, simple phobia leads to avoidance of ordinary activities such as flying, heights, animals, and confining spaces. Simple phobias range in their effects on sufferers' lives from trivial to profoundly disabling, depending on the time spent thinking about the fears and the effects of avoidance in the clients' lives.

SOCIAL PHOBIA:

Social phobia is the morbid fear of embarrassment, which leads to avoidance of social experiences. Sometimes it is limited to public speaking, and at other times it is a pervasive shyness, which limits exposure to unfamiliar social situations and unfamiliar people. Public speaking phobics are often excellent speakers and are usually not shy in other social situations. The more pervasive social phobia syndrome can have profound negative effects on a person's life, commonly causing premature school leaving and failure to develop friends, as well as inhibiting dating and marriage.

OBSESSIVE-COMPULSIVE DISORDER (OCD):

Obsessions are repeated unwanted, repugnant thoughts. Compulsions are ritualized actions taken to reduce the distressing feelings produced by the obsessions. Hand washing and checking are typical compulsions. OCD thoughts and behaviors can consume many hours every day and leave the sufferers only when they sleep.

POST-TRAUMATIC STRESS DISORDER (PTSD):

PTSD, sometimes not listed with the other anxiety disorders, is associated with depression, panic attacks, and anxiety. Avoidance and substance abuse may also become problems. PTSD follows an unusual and overwhelming stress such as a severe fire or assault. Nightmares and flashbacks that recall the trauma are common.

GENERALIZED ANXIETY DISORDER (GAD):

GAD is the anxiety disorder with excessive and unrealistic worries that last for at least 6 months. Worries often focus on one or more life circumstances, usually

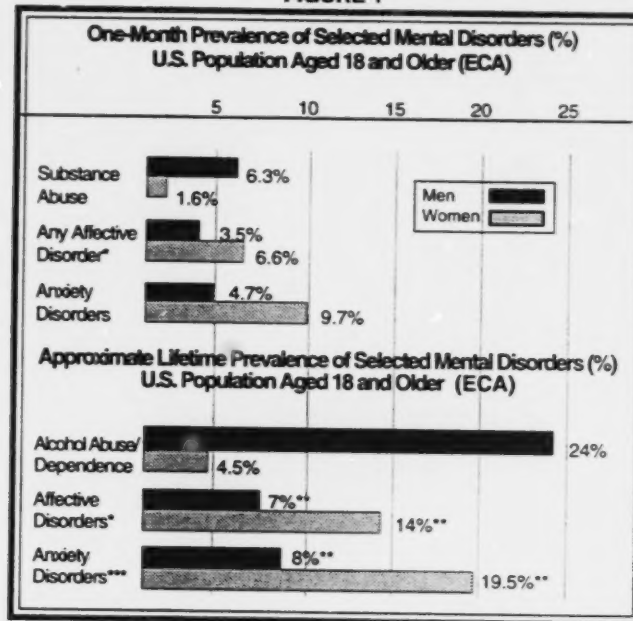
health, finances, safety, or occupation. Like the other anxiety disorders, it tends to wax and wane over a lifetime and to range in severity among clients from minor to profoundly disabling.

As a group, the anxiety disorders are associated with excessive worry. As one of my anxious clients said, "I have had a terrible life, but most of it never happened." He did not mean that his suffering, and the disabilities he endured because of his anxiety disorder, did not happen. He meant that the events he feared, such as dreaded illnesses afflicting himself and his family members, accidents, and personal financial disasters, did not happen on the everyday basis as did his unrealistic but crippling worries. Anxious people tend to be perfectionistic and to have highly developed consciences. They often report that they are sensitive to medicines and are accordingly often reluctant to use them. I call the anxiety disorders "disorders of quality people," because so many anxious clients are good people with bad disorders.

Epidemiology

The Epidemiological Catchment Area (ECA) study of the National Institute of Mental Health, which is based on a sample of households (not a clinical sample of clients in therapy) and uses DSM-III diagnostic criteria, is now rewriting the epidemiology of mental disorders (Regier, et al., 1984). The anxiety disorders are the most prevalent mental disorders in the United States, affecting 19.5% of women and 8% of men in their lifetimes, and 9.7% of women and 4.7% of men in a 6-month period. (See Figure 1). Figure 1 also shows the lifetime and 6-month prevalence of the other major groups of mental disorders, the affective disorders, and the substance use disorders. Figure 2 shows the interrelationships and high level of comorbidity of the substance use disorders with other mental disorders.

FIGURE 1



* Includes major depressive episode, dysthymia, manic episode

** Numbers are elevated slightly because persons with multiple diagnoses are counted more than once.

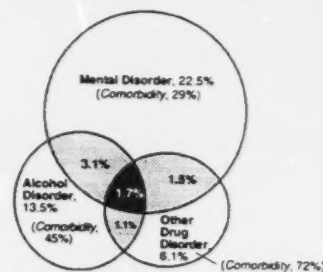
*** Includes panic disorder, agoraphobia, obsessive-compulsive disorder, simple phobia. Does not include social phobia, generalized anxiety disorder, post-traumatic stress disorder, or adjustment disorder with anxious mood.

Adapted from: Robins et al. Copyright 1984, American Medical Association. McGlynn, T.J., & Meicall, H.L. (Eds.). (1989). *Diagnosis and Treatment of Anxiety Disorders: A Physician's Handbook*. Washington, DC: American Psychiatric Press, Inc.

FIGURE 2

Lifetime Prevalence of Comorbid Mental and Addictive Disorders

Combined community and institutional 5-state epidemiologic catchment area data standardized to the U.S. population



Source: Regier, D.A., Farmer, M.E., Rae, D.S., et al. (1990). Comorbidity of mental disorders with alcohol and other drug abuse. *Journal of the American Medical Association*, 264, 2511-2518.

Among clients with one of the anxiety disorders, about 24% have a lifetime substance abuse disorder. Conversely, about three out of four people with anxiety disorders have never had a substance use disorder or suffered from abuse of or dependence on alcohol or other drugs. People comorbid for anxiety and SUD are often seen in chemical dependence therapy settings. They are less often seen in settings primarily treating anxiety disorders because of the primacy of the substance abuse disorder in the clinical picture for most dual diagnosis clients (U.S. Department of Health and Human Services, 1991).

Defining the Clinical Problem and the Goals of Therapy

A cure for an anxiety disorder, as for all chronic illnesses, lies in knowing what is wrong and what to do about it. Health care professionals can educate clients about the anxiety disorders, helping them understand the available treatments and their likely results. Clients need to know that the anxiety disorder has biological roots—that it is not the result of poor coping skills or other failures of the client any more than are most other serious disorders. Like many other illnesses, the anxiety disorders also have important psychosocial dimensions. The anxiety disorders are associated with dreadful feelings. However, the anxious feelings will not lead to loss of consciousness, loss of control (other than avoidance), or physical illness (such as heart attacks). These facts are helpful to many anxious clients who suffer from guilt over their illness and from the fear that their panic and anxiety will lead to something even more dreadful.

Research has shown that clients with panic disorder suffer an excess of serious disorders such as heart attacks and suicide. After working with thousands of clinically anxious clients and finding them to be generally physically healthy despite their often extreme health fears (understandably fed by their experiences of panic), I

have concluded that some panic disorder clients who do not know what is wrong with them, and who do not receive therapy, are indeed at added risk of many bad outcomes because of their own fears of the illness. However, once anxious clients understand their illness and get effective therapy, they appear not to have excessive rates of cardiac or other stress-related illnesses, including depression, suicide, and heart disease (*Journal of Clinical Psychiatry*, 1990).

Some clinically anxious people are involved in lawsuits, workers' compensation, or similar financial entanglements related to their anxiety disorders. It is especially common for PTSD clients. Although some of these anxious clients may be malingering, my experience is that malingering is uncommon. Rather, many of these compensation-related anxious clients are caught in a particularly cruel "what-if trap": if they get better, their claim is denied or is reduced in value. I have rarely seen one of these clients get better from their anxiety problem until the lawsuit is settled and they no longer have financial gain from being ill. If the clinically anxious client is to get well, it is essential that the anxiety problem be identified correctly as bad feelings that are inside the client. Only by accepting responsibility for these feelings and the behaviors to which the feelings give rise can anxious clients begin the process of recovering control of their lives.

In helping my clinically anxious clients understand their illness, I personify the panic and other worry symptoms as a dragon who attacks the client in a terrifying fashion. The dragon can scare the client, but that is the limit of his power. The dragon's game is to use blackmail to get the client to stay in his dungeon. The dragon says, "If you don't do X, I will go easy on you!" The frightened sufferer from an anxiety disorder often agrees because of the nameless but overwhelming terror of the consequences of future dragon attacks. This is the basis of the avoidance that produces the disability commonly seen in anxious clients. Like all blackmailers, the dragon is

never satisfied. Over time he wants more and more of the client's life. The dragon feeds on the client's fear. This is the only food the dragon can eat. The more the client fears the dragon, the larger the dragon grows. Once the client stops fearing the dragon, the dragon withers away and ultimately dies of starvation.

The most appropriate and achievable goal of therapy for anxiety disorders is a full, normal life without restriction because of the anxiety disorder. The realistic goal of therapy is not to end the symptoms of anxiety. In fact, efforts to end the symptoms are part of the problem, because they set up expectations that cannot be fulfilled and lead to a sense of failure and demoralization for both the doctor and the client.

Cognitive therapies and other effective psychological therapies primarily affect the second fear—they reduce anticipatory avoidance. Behavioral therapies reduce avoidance. Because anticipatory anxiety and avoidance set the trigger for panic, these psychological approaches also reduce the panic, the first fear. The vicious cycle of panic, anticipatory anxiety, and avoidance is reduced at different points by different therapies. By reducing any component of the anxiety disorder, the cycle is slowed and the client's life is improved. Many clients benefit from concurrent combined treatments affecting all three components of the anxiety disorder cycle simultaneously.

Understanding anxiety and its treatment is the foundation for all successful approaches to the anxiety disorders, with or without pharmacotherapy. Therapy helps the client cope better with a seriously distressing disorder that is rooted in biology but has important psychosocial dimensions, even though the disorder cannot be banished. A cure is regaining control of one's life, not eliminating all the underlying feelings of anxiety arising from a hair-trigger alarm system. This approach is

different from earlier psychological formulations of the anxiety disorders, which were based on the assumption that the client's anxious symptoms reflected poor coping skills (e.g., people who did not suffer from anxiety disorders were able to cope better with life's problems than were those who had anxiety disorder) or that the anxiety flowed from unique stresses that were not endured by those who did not have these painful chronic disorders.

This newer formulation of the anxiety disorders and their therapies is easily understandable by both therapists and clients. It respects the client's suffering, it offers important roles for both the mental health counselor and the client, and it fits with the understanding that these are biologically based, often lifelong disorders—and that the client is neither guilty nor weak. This formulation of the anxiety illness and its therapies is a basis for a solid therapeutic alliance between the client and the professional, one based on respect and a shared understanding of the disorder. It works equally well with psychological and pharmacologic therapies.

As with substance use disorders, clients suffering from anxiety disorders are not responsible for having the disorder, but they are fully responsible for what they do with it. Recovery is indeed possible, in the sense that clients can regain full control of their lives, but recovery from an anxiety disorder requires learning and hard work sustained over a long period of time, often with therapists and clients working together.

The Psychological Therapies

COGNITIVE-BEHAVIORAL:

A wide variety of techniques are bundled in the descriptive phrase "cognitive-behavioral therapy," and they have at their heart two characteristics (Barlow, 1988; Marks, 1982). The cognitive part of the new psychological prescription for anxiety

disorders means helping clients develop a new understanding of the nature of the distress they experience and new ways to think about getting well. The key objectives of cognitive restructuring of clinically significant anxiety is to respect the suffering and to reduce the guilt and fear the clients often feel (Mavissakalian, & Barlow, 1981).

Claire Weekes, an Australian general practitioner, was the guiding clinician in this new approach. Her short, easy-to-understand books—though by now quite old-fashioned—are still the most helpful to many clients (Weekes, 1969; Weekes, 1972; Weekes, 1987). Her four suggestions to clients for confronting panic in phobic situations were: facing, accepting, floating (not fighting), and letting time pass.

When anxious clients do not manifest behaviors characteristic of their anxiety (for example, clients with GAD, panic disorder clients without avoidance, and OCD clients without compulsions), the psychological therapy is, paradoxically, often more difficult. It is not possible to conduct behavioral therapy because there is no pathological behavior to overcome. For these clients, effective therapy requires them to change their thoughts, making the cognitive aspects of therapy preeminent. Recovery often means helping clients learn to accept the symptoms and to put them into realistic perspective—as upsetting, but not scary. With such acceptance, the distressing thoughts usually diminish in both frequency of occurrence and severity over time, although they usually do not disappear completely. They become unimportant and thus no longer distressing.

The behavioral part of this new therapy is called “supported exposure.” It involves helping the client, as rapidly as possible but as slowly as necessary, to do precisely those things that produce the panic and other uncomfortable feelings of anxiety. Persuading anxious people to enter panic-generating situations is always

difficult, and sometimes impossible. It is useful to work with anxious people in groups, so they can meet fellow sufferers and see them confront their fears and thereby become free of disability. They are also surprised and pleased to find how normal other anxious people appear because they fear that they themselves look and act bizarre.

It can be helpful for the therapist or another recovering anxious person to accompany the client into the anxiety-generating experiences, especially at first. Psychologists can learn a great deal about the experience of anxiety and panic by accompanying their clients into phobic- or panic-generating situations. The cure for anxiety disorders, and the understanding of the disorders, does not lie in the therapist's office but in the client's life outside the office. Dr. Weekes offers a succinct definition of a cure for anxiety disorders: "A cure is when the symptoms no longer matter."

It is essential in the behavioral approach to the anxiety disorders to have the client do the things that cause distress over and over again, every day. The client should stay in the anxiety-provoking situations for prolonged periods of time, learning that the panic subsides, over time, even without fleeing or avoiding panic-producing experiences. Only with repeated and prolonged exposure can desensitization to panic-generating experiences take place (Zane, 1989).

In talking with clients about the behavioral approach to a cure of an anxiety disorder, I use the analogy of an allergist desensitizing a client to bee venom: at first the dose of venom is small, but with repeated injections, the clients become easily able to endure exposures which would initially have been overwhelming. This analogy also explains why the panic-producing experiences are so difficult for the clinically anxious client: their nervous systems are sensitized to experiences to which other

people are not sensitive, just as the person who has a bee sting allergy is unusually sensitive to bee venom. Both the problem (allergic sensitization) and the solution (desensitization) lie within the client who has the disorder, not in the bee. Also, like the allergic person, the anxious person's sensitization is not a sign of moral weakness or failure as a human being.

Why does desensitization in therapy work as well as it does? If all it took for a client to get well was to experience the distress of the panic, this should be a self-curing disorder, since clinically anxious clients, despite their often strenuous efforts to avoid panic-generating situations, are frequently confronted by panic in their everyday lives. These everyday exposures do not produce lowered sensitization, while exposures to panic in behavioral therapy do. The difference lies in the understanding of the anxiety disorder. White-knuckle exposure, which is how the anxious person outside of therapy experiences panic, worsens the disorder because it is rooted in fear.

In contrast, when clients understand their disorder and voluntarily and repeatedly submit themselves to panic-generating experiences, especially when they learn to do so without adding fearful thoughts to their painful feelings, when they can float through panic like a limp rag doll, then they move from sensitization to desensitization, from prison to freedom. In working with anxious clients, I find these phrases helpful: "Nothing is but thinking makes it so," and, "There is no heaven that thinking cannot make a hell, and no hell that thinking cannot make a heaven." In other words, "Your panic and anxiety are what you make them by your thoughts."

PSYCHOTHERAPY:

In addition to cognitive-behavioral therapy, which is the mainstay of modern psychological treatments of anxiety disorders, clinically anxious clients often benefit

from more traditional psychotherapy, including individual, family, and group therapy. It is important not to oversell such types of therapy to anxious clients. They are not likely to remove the anxiety or provide the quality of relief that cognitive-behavioral therapy can. Rather, these nonspecific psychological treatments can be effective in dealing with the real and important human problems the client has, which may or may not relate to the anxiety symptoms themselves.

SELF-HELP:

As part of the remarkable self-help movement that is sweeping the United States, especially during the last decade, increasing numbers of self-help groups have been created for anxious persons. Such groups offer a unique opportunity for support. They also help clients with anxiety disorders learn from other sufferers about the various therapists and therapies being used in their area, because mutual-aid meetings provide a consumers' eye view of the provider system. The one negative feature of self-help is that it can sometimes deteriorate into an environment in which anxious people complain about their illnesses and justify their failure to confront their fears—what Alcoholics Anonymous calls “the pity pot.” Having leaders in mutual-aid groups, either professionals or people who are well along in their own recovery, can reduce this unhealthy tendency. Unlike Alcoholics Anonymous and other established 12-step programs, self-help for the anxiety disorders lacks a clear program and a set of guidelines for recovery, although there have been attempts to use 12-step principles (Saylor, DuPont, & Brouillard, 1990).

BIBLIOTHERAPY:

Self-help books on anxiety have been popular for many decades. In fact, self-help books dealing with fear and anxiety were bestsellers before the modern anxiety diag-

noses were established. Today are many such books are available, both for clients and for therapists using all therapy approaches.

ADJUNCTIVE TECHNIQUES:

In addition to specific cognitive-behavioral therapy and nonspecific psychotherapy, some anxious clients find a variety of adjunctive techniques useful, including **exercise, diet, and the elimination of potentially anxiety-provoking substances, especially alcohol and caffeine.** Aerobic exercise, which produces pounding heartbeats, can be frightening to clients suffering from panic and other anxiety problems, so they often quit exercising. Clients need to learn that this rapid heartbeat is not only normal, but beneficial. Aerobic exercise is also helpful in reducing depression and in building self-confidence. Some anxious clients find that by eliminating their use of caffeine and alcohol, they can reduce their panic and anxiety.

It is always desirable as part of therapy to have anxious clients stop drinking alcohol and beverages containing caffeine for a month. Caffeine is a stimulant that can precipitate panic attacks; alcohol reduces anxiety briefly after use, but when the effects of the alcohol wear off after a few hours, clients who are vulnerable to panic and other anxiety disorders often experience major and prolonged upsurges of symptoms. Many anxious clients have not made the connection between their distressing symptoms and their use of caffeine and alcohol because the increase in symptoms occurs some time after their use of the substances, whereas the acute effect, especially of alcohol, can be experienced as beneficial for the anxiety.

A variety of other nonspecific psychological therapies can also be useful in reducing anxiety symptoms and related disorders. They include **assertiveness training, stress management, relaxation training, and therapy designed to assist individual clients with problems such as incest and rape as well as children of alcoholics**

and other life problems, which may be important factors in particular anxious clients' lives. These therapies, like traditional psychotherapy, are often useful for anxious clients, but they do not take the place of cognitive restructuring and active confrontation of the fear-generating experiences in real-life situations. People participating in these nonspecific therapies must also guard against excusing the disabilities resulting from their anxiety disorders and unwittingly perpetuating the disabilities. If the clients are to get well, they need to take personal responsibility for their own anxiety disorders and their own recoveries, no matter how the symptoms of anxiety got started.

Integration of Psychological and Pharmacologic Therapies

There is an unfortunate tendency to view psychological and pharmacologic therapies as alternatives, as competitors, in the therapy marketplace. A more constructive and realistic view is that the goal of all therapy is intended to help anxious clients live full, normal lives without limitations because of their anxiety disorders. **Both treatments can be useful in achieving this goal, often in combination.** No therapy helps every anxious client who tries it, and no therapy fails to help anyone. Abundant clinical experience demonstrates that psychological and pharmacologic therapies do not detract from each other but often produce synergistic beneficial effects. After decades in which sufferers from anxiety disorders had no effective treatment at all, it is now a happy reality that there are a wide and growing range of effective therapies, all of which show promise.

Further information about the nature and treatment of the anxiety disorders can be obtained from the following:

- Anxiety Disorders Association of America (ADAA)
6000 Executive Boulevard, Suite 200
Rockville, MD 20852
(301) 231-9350
- National Anxiety Foundation
3135 Custer Drive
Lexington, KY 40501-4001
(606) 272-7166
- Obsessive-Compulsive Disorder Foundation, Inc.
P.O. Box 60
Vernon, CT 06006
- National Institute of Mental Health
Public Inquiries
5600 Fishers Lane, Room 15C05
Rockville, MD 20857
(301) 443-4515
- Phobics Anonymous
World Service Headquarters
P.O. Box 1180
Palm Springs, CA 92263
(619) 322-COPE.

Information on **pharmacologic treatments for anxiety disorders** is available from
Directions in Psychiatry, Volume 12, Lesson 25.

Reprints of this lesson are \$4 plus \$1 shipping and handling, and can be obtained by calling
1-800-367-2550 or by writing to:

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Questions Based on This Lesson

1. According to the author:
 - A. Cognitive treatments primarily affect the second fear: reducing anticipatory avoidance
 - B. Anxiety disorders are exclusively the result of psychosocial stress factors and early childhood developmental trauma
 - C. Patients with anxiety disorder are at extremely high risk for death from heart disease whether they seek treatment for their condition or not
 - D. The realistic goal of treatment is to end the symptoms of anxiety
2. Which of the following is *not* one of the four suggestions that Claire Weekes made for patients confronting panic?
 - A. Facing
 - B. Fighting
 - C. Accepting
 - D. Letting time pass
3. Which of the following statements about the management of anxiety disorders is *true*?
 - A. Avoiding caffeine helps to reduce the incidence of anxiety attacks
 - B. Alcohol is especially useful in reducing the intensity of panic
 - C. Aerobic exercise should never be done because they increase the risk of heart disease
 - D. Assertiveness training is contraindicated
4. In the behavioral treatment of anxiety disorders, called supported exposure:
 - A. Groups should not be used since these consistently aggravate avoidance behavior
 - B. The anxious person should be encouraged to go into the anxiety-generating situations alone, because the presence of someone else can only intensify fear and the urge to avoid
 - C. Exposure to anxiety-generating situations should not be done frequently or over a long period of time, but rather once or twice, to prevent demoralization
 - D. It is helpful for someone, including the therapist, to accompany a recovering anxious person into anxiety-generating experiences

Directions in Mental Health Counseling

VOLUME 3 • LESSON 2

Improved Detoxification from Drugs and Alcohol through Nutrition

Jeffrey S. Bland, PhD

Dr. Bland is Founder and Chief Executive Officer of HealthComm Inc, Gig Harbor, WA.

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EDITOR'S NOTE

The role of nutrition in the rehabilitation of substance abusers (especially alcoholics) is a topic that has received increasing attention in recent years. Nonetheless, nutritional intervention remains a relatively overlooked method in the management of substance abuse today. A primary reason for the underuse of nutritional therapy is that most counselors are not trained specifically in nutrition's effects on the liver detoxification process. However, as the author indicates, one does not have to be an expert in nutrition to apply it in a counseling context.

Dr. Bland and his colleagues have extensively researched the link between nutrition and the prevention of disease. In this lesson, he presents a straightforward discussion of the detoxification process. Although various therapeutic approaches to treating substance abusers have been shown to be effective, only through proper nourishment can the damaging physical effects of drug and alcohol detoxification be minimized. Accordingly, Dr. Bland highlights so-called "protector" nutrients and minerals that even aid in reducing withdrawal effects.

Knowledge of key nutrients and minerals is but the first step in using nutritional intervention as an effective therapy for substance abusers. It is indeed imperative to be aware of a substance abuser's history of drug, cigarette, and medication use; however, the client's current nutritional status should also be assessed. Once this is accomplished, a detoxifying diet can then be implemented for the client so that nutritional therapy can achieve optimum results. Dr. Bland includes a Metabolic Screening Questionnaire for nutritional status evaluation, a sample detoxification diet, and an 800 telephone number for more information on this diet, to help make nutritional intervention a practical therapeutic option for substance abuse counselors.

Introduction

Alcoholism and other substance abuse problems share many features, one of which is a relationship to poor nutrition. Because alcohol and other abused substances suppress appetite and alter food consumption patterns, the addicted person often displays poor nutritional status, which further impairs the proper absorption of nutrients and in turn exacerbates nutritional problems.

Furthermore, substance abuse has a distinctly adverse impact upon the body's detoxification mechanisms, which take place principally in the liver. Derangement of the detoxification process can result in an exposure to metabolites (breakdown products) of alcohol and other chemical substances, which further contributes to the physiologic addiction process.

The Pathophysiology of Substance Abuse

Alcohol and other substances of abuse are metabolized by the liver by a family of detoxification enzymes called cytochrome P450 (Ruckpaul, & Rein, 1989). These liver enzymes are inducible: when a person is addicted to a specific substance, his or her body tries to compensate for the exposure by enhancing the level and activity of these enzymes. However, the liver simultaneously produces a class of secondary toxins called oxygen free radicals. The production of these substances is associated with damage to the liver, brain, digestive tract and nervous system of the addict.

The Role of Nutrition

To protect against the damaging effects of these toxic chemicals and the breakdown products of alcohol and drug detoxification, the body requires

proper nourishment with various protector nutrients, such as vitamin C, vitamin E, and carotene (the orange-red pigment from fruits and vegetables such as carrots), as well as such minerals as zinc, manganese, and copper. Adequate intake of dietary protein is also very important to help support the body's proper detoxification pathways (Anderson, & Conney, 1979).

With proper nourishment, the damaging effects of the detoxification process are minimized, and the withdrawal effects during the "drying-out" period are reduced. Many therapists have found that those who are addicted to alcohol and other substances can experience improved success in a treatment program if they are properly nourished with the protector nutrients, the B-complex vitamins, and magnesium. Doses of nutrients that have been employed for this use are listed in Table 1.

Improvements in nutritional status enable the liver to perform its function in detoxification without damage to the body from the toxic effects of oxygen free

radicals. The reduction of toxic substances through improved detoxification also results in lowered addiction potential.

Nutritional intervention is an often-overlooked tool in the management of substance abuse. Because most therapists are not trained in nutrition and its effects upon detoxification, application of this important adjunctive method of therapy is not included in the

TABLE 1
Nutrients Appropriate for
Those Undergoing Detoxification

200 IU vitamin E
1000 mg vitamin C
10 mg carotene
10 mg vitamins B ₁ , B ₂ , and B ₆
50 mg vitamin B ₃
20 µg vitamin B ₁₂
400 µg folic acid
20 mg zinc
2 mg copper
5 mg manganese
400 mg magnesium
70 g high-quality dietary protein

comprehensive client management plan.

Fortunately, the therapist need not be an expert in nutrition to apply this nutrition concept. Over the past 4 years, we have been involved in the development and evaluation of a simple and effective nutritional intervention program to assist in liver detoxification. Once understood, this program can easily be applied to clients who may suffer from a variety of substance abuse problems. It can be integrated within all traditional approaches to managing substance abuse in order to improve program success, lower recidivism, and reduce the adverse health effects associated with substance abuse and its treatment.

Evaluating Nutritional Status

We have devised a method to evaluate liver function with regard to detoxification. With this information, the nutritional component of the treatment program can be implemented. Its success can be followed by an evaluation of the program's effect on the liver's ability to detoxify toxic substances and render them ready for excretion. The test requires the client to consume a standard dose of caffeine in purified form along with a measured dose of sodium benzoate, a common food preservative that retards mold growth. Saliva samples are taken at 2 and 14 hours after the caffeine administration, and urine is collected for 4 hours. The saliva samples are tested at the laboratory (MetaMetrix Laboratory, Norcross, Georgia) for caffeine levels and the urine for hippuric acid, the detoxification product from sodium benzoate. **The more rapidly the caffeine disappears from the saliva and the more hippuric acid excreted in the 4-hour urine sample, the greater the rate of detoxification** (Renner, Wietholtz, Huguenin, et al., 1984; Tietz, 1976). This protocol has been used extensively in our studies to evaluate liver detoxification status and to follow the success of a nutritional

intervention program designed to improve the effectiveness of a treatment program.

Altered test values for either caffeine or benzoate reveal modified or ineffective detoxifying function of the individual's liver. Indications of poor detoxification ability is predictive of a more difficult course and the potential for compliance or outcome. Recent studies indicate that those individuals who have multiple chemical or substance abuse exposure may have an even more difficult time in detoxification. **Drugs, alcohol, cigarettes, and medications all work together to alter the detoxification ability of the liver; these complicating factors make it even more important to implement a nutrition intervention program.**

The Detoxification Diet

We have developed a specific diet that is high in nutrients known significantly to improve or "upregulate" the detoxifying capability of a liver that has reduced functional liver capacity. Earlier studies had already shown that diet is very important in the regulation of cytochrome P450 and that it can also be affected by the amount and type of protein, fat, and carbohydrate in the diet. Other research had revealed that specific vitamins, minerals, and conditionally essential nutrients, such as glutathione and the amino acid L-cysteine, can influence liver detoxification.

We conducted a 21-day, placebo-controlled intervention trial to evaluate the effect of this nutrient-tailored diet on the liver's ability to process foreign substances and prepare them for excretion. The caffeine and benzoate tests were used to evaluate liver function during this study. The test and placebo diets were very similar in calories but differed in the level of specific nutrients recognized to help support improved liver detoxification.

Participants were evaluated before and after the test diet or placebo intervention by

FIGURE 1
Metabolic Screening Questionnaire

Rate each of the following symptoms based upon your health profile for the past 30 days

POINT SCALE

- 0 = **Never or almost never** have the symptom
 1 = **Occasionally** have it, effect is **not severe**
 2 = **Occasionally** have it, effect is **severe**
 3 = **Frequently** have it, effect is **not severe**
 4 = **Frequently** have it, effect is **severe**

DIGESTIVE TRACT	_____	Nausea or vomiting	Total _____
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching or passing gas	
	_____	Heartburn	
EARS	_____	Itchy ears	Total _____
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	
EMOTIONS	_____	Mood swings	Total _____
	_____	Anxiety, fear or nervousness	
	_____	Anger, irritability, or aggressiveness	
	_____	Depression	
ENERGY/ ACTIVITY	_____	Fatigue, sluggishness	Total _____
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	
EYES	_____	Watery or itchy eyes	Total _____
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision (does not include near- or far-sightedness)	
HEAD	_____	Headaches	Total _____
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	
HEART	_____	Irregular or skipped heartbeat	Total _____
	_____	Rapid or pounding heartbeat	
	_____	Chest pain	
JOINTS/ MUSCLES	_____	Pain or aches in joints	Total _____
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Pain or aches in muscles	
	_____	Feeling of weakness or tiredness	

the caffeine and benzoate tests. The physical signs and symptoms experienced by the participants in this study were evaluated using the Metabolic Screening Questionnaire (Fig. 1). Scores greater than 100 points on the questionnaire are indicative of significant toxicity problems needing nutritional support, whereas scores between 50 and 99 points indicate moderate health problems associated with metabolic toxicity. The questionnaire is derived from the Cornell Medical Index, a well-respected medical evaluation instrument, and has now been used with several thousand people going through a detoxification program to follow the success of the program.

The results of this placebo-controlled diet intervention program were quite remarkable. Before the diet intervention, the liver detoxification ability of both the test and placebo groups was slightly abnormal. After intervention with the diet for 21 days, however, a statistically significant difference ($p < 0.05$) between the test diet group and the placebo group was seen. The test diet group showed improved liver detoxifying ability not seen in the placebo diet group. This improvement was also mirrored in the improvement in the self-rated symptoms, as measured from the questionnaire. The initial symptom scores from the questionnaire were the same in both the test and placebo diet groups, but after diet intervention, only the test diet group had a significant reduction in health complaints.

Relationship of Toxicity to Health Problems

The study results point to an important relationship between improvement in liver detoxification ability and the decrease in chronic health problems and symptoms associated with toxicity. It is important to recognize that a number of contributions to toxicity symptoms may exist in the addicted. Long-term consumption of excessive alcohol, for example, is known to damage the sensitive lining of the intestinal

tract, allowing absorption into the body of toxic substances that may further aggravate toxicity symptoms (Waals, 1991). Substance abuse can also alter the types and numbers of toxin-producing bacteria in the intestinal tract, which can contribute to alterations in brain function and cognitive behavior. The liver is very important for "cleansing" the blood of these toxins before they can reach the brain and alter brain chemistry. Therefore, if the liver's detoxifying function is impaired, the result is increased damage to the nervous system (Allen, 1991).

Substance abusers may also become more "allergic" as a consequence of the damaging effects of toxins upon the immune system. Health problems, such as irritable bowel syndrome, eczema, and arthritis are all associated with the toxic burden that accompanies alteration in digestive and immune function in substance abusers. Avoiding foods that tend to produce food intolerance symptoms—such as dairy products, cereal grains other than rice, yeast, shellfish, and citrus fruits—may help bring relief of symptoms in those suffering from these disorders. Hunter has pointed out that alteration of digestive function and intestinal bacteria may alter liver function as a result of the release from toxic bacteria of substances that alter immune function and could result in symptoms of arthritis (Hunter, 1991). Even the appearance and progression of nervous system diseases may be the result of exposure of the nervous system to toxins that were not properly detoxified by the liver. Steventon and his colleagues found that those who had Parkinson's disease had significantly reduced liver detoxification ability. From their work, they concluded, "Parkinson's disease patients may be unusually susceptible to exogenous or even endogenous toxins" (Steventon, Heafield, Waring, & Williams, 1989).

In our work, we found liver function in a group of nondiseased persons to vary widely when evaluated by the caffeine and benzoate tests. This variation of liver detoxifying ability may be linked to the susceptibility of a substance abuser to the

TABLE 2
The Nutrient Composition of the Two Base Powdered Meal Supplement Products

<i>Nutrient</i>	<i>Test</i>	<i>Placebo</i>
Calories	450	300
Protein	45 g	30 g
Carbohydrate	51 g	40 g
Fat	9 g	2 g
Fiber	6 g	8 g
Sodium	180 mg	320 mg
Potassium	1260 mg	1380 mg
Vitamin B ₁	6 mg	1.1 mg
Vitamin B ₂	6 mg	1.2 mg
Vitamin B ₃	21 mg	14 mg
Vitamin B ₄	10.2 mg	1.4 mg
Vitamin B ₁₂	10.8 mg	4.2 mg
Folic acid	240 mg	200 mg
Pantothenic acid	10.5 mg	7 mg
Biotin	405 mg	210 mg
Vitamin C	900 mg	42 mg
Vitamin A	15,000 IU	3500 IU
Vitamin E	324 IU	22 IU
Calcium	600 mg	500 mg
Magnesium	420 mg	200 mg
Iron	10.8 mg	12.6 mg
Zinc	30 mg	10.5 mg
Copper	3 mg	1.4 mg
Phosphorus	600 mg	500 mg
Manganese	3.9 mg	2 mg
Selenium	120 mg	60 mg
Chromium	150 mg	134 mg
Molybdenum	360 mg	100 mg
Iodine	159 mg	105 mg
L-Glutathione	10 mg	—
L-Cysteine	5 mg	—
N-Acetyl Cysteine	5 mg	—

secondary health effects associated with drug and alcohol problems.

The Detoxifying Diet

Because a tailored diet can improve liver detoxifying ability, this nutritional intervention program is believed not only to help improve the success of a treatment program but also to **reduce the health risks associated with substance abuse**. By using a diet that supplies readily digestible high-quality nutrition that is high in specific nutrients supportive of detoxification, a significant improvement in both digestive function and liver detoxifying ability can be realized.

This unique detoxifying diet makes use of specific nutrients that improve digestion and assimilation of nutrients while providing the important nutrients in the correct level to help

support the body's natural detoxification process. In a sense, this diet might be considered to fit the definition of a medical food. A medical food differs from traditional food by supplying specific tailored nutrients at levels that can support unique physiological processes associated with certain health needs. The diet composition of the program for detoxification is shown in Table 2 on the following page. It should be noted that this diet supplies not only adequate calories and levels of the essential vitamins and minerals but also special nutrients such as the amino acid L-cysteine, glutathione, and molybdenum, which have been shown to be very important for the liver's detoxification process (Ketterer, Coles, & Meyer, 1983). An example of the application of the diet is shown in the 4 days' menu plan described in Table 3. (A more complete description of the 21-day diet plan and nutritional formula can be obtained by calling 1-800-843-9660).

TABLE 3
Sample Diet, Days 1 through 4

DAY 1	
Breakfast*	Test diet formula
Snack #1 ¹	Apple or papaya
Lunch*	Test diet formula Carrot and celery sticks
Snack #2*	Test diet formula
Dinner*	White rice Peas and zucchini
Snack #3*	Pears (fresh or canned without sugar)
DAY 2	
Breakfast	Test diet formula
Snack #1	Pear(s)
Lunch	Test diet formula White rice
Snack #2	Test diet formula
Dinner	Baked sweet potato or yam Green beans Sliced cucumber
Snack #3	Banana
DAY 3	
Breakfast	Test diet formula
Snack #1	Peach(es)
Lunch	Test diet formula White rice
Snack #2	Test diet formula
Dinner	Baked winter squash Steamed broccoli or cauliflower
Snack #3	Kiwi fruit
DAY 4	
Breakfast	Test diet formula
Snack #1	Melon
Lunch	Test diet formula Carrot and celery sticks
Snack #2	Test diet formula
Dinner	White rice Peas and zucchini Broccoli
Snack #3	Kiwi fruit
8 a.m.*	
10 a.m. ⁵	
noon*	
3 p.m.*	
6 p.m.*	
8 p.m.*	

The diet can help improve the conversion of toxic substances in the liver to nontoxic materials that are prepared for excretion in the urine or bile. Because this diet has been demonstrated to help in several of the liver's detoxification processes, including cytochrome P450 as well as conjugation activity, it helps to convert substances to less-toxic byproducts. This is very different from the effects of certain drugs or alcohol, which activate cytochrome P450 but do not improve the function of the conjugation steps. Therefore, drugs and alcohol may increase the body's toxic reaction, because the intermediate substances produced by the action of cytochrome P450 may be more toxic than the initial substances (Caldwell, 1982). It is only through the proper balancing in the liver of all the steps of detoxification that a nontoxic substance is produced and the withdrawal symptoms are reduced. This is the advantage of a tailored nutritional approach to improving liver detoxification, because each of the liver's detoxification processes is normalized, resulting in improvement in the excretion of nontoxic substances.

Antioxidant nutrients, such as vitamins C, E, and carotene, are very important in minimizing damage to the body that might occur as a consequence of an increase in the rate of detoxification during drug or alcohol treatment. The overall beneficial effects of the diet on the liver's detoxifying ability, therefore, are a result of the combined influence of the easily digested white rice protein concentrate, the energy-efficient dietary fat source of medium-chain triglycerides, easily-digested carbohydrates with a very low potential for fermentation in the gut to toxic substances (high-molecular-weight dextrins from rice), and the specific nutrients known to support the liver's effective detoxification processes, such as zinc, copper, manganese, iron, B-vitamins, and the antioxidant vitamins.

The most significant improvement in toxicity-related symptoms seen within the first 10 days of the diet included reductions in "tired eyes," "pain behind the

eyes," headaches, digestive disturbances, morning pain and stiffness, and chronic respiratory complaints.

Conclusion

My colleagues and I concluded from this research that a specific nutrient-tailored diet can be very helpful in improving the potential for positive results in programs designed to treat alcohol and drug dependence. This 21-day diet, the first week of which is outlined in Table 3, has demonstrated its ability to support improved liver detoxification. **The remarkable difference between this dietary approach and traditional drug treatment to enhance liver function is that this diet improves both the first- and second-phase detoxification reactions, resulting in the excretion of fully detoxified substances.** It is very rewarding to witness the significant reduction of many of the chronic health complaints associated with toxicity during the 21-day diet intervention. This dietary approach is easily implemented and has demonstrated very high compliance, resulting in improved program success. As a result of this work, we suggest that all clinical management programs for substance abuse would experience improved success and reduced recidivism by implementing the proper nutrient-tailored diet intervention program.

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Questions Based on This Lesson

5. Which of the following statements is correct?
- A. Nutritional intervention is an underused tool in substance abuse management because nutrition's effects upon detoxification remains unclear today
 - B. Drugs and their interactions may increase toxic reactions in the body since intermediate substances from cytochrome P450 are, in fact, less toxic than the initial substances
 - C. A reduction in blood pressure is one significant improvement realized within the first 10 days of the nutritional diet outlined in this lesson
 - D. An increased amount of hippuric acid excreted in a urine sample is indicative of a higher rate of detoxification
6. Which of the following nutrients or minerals is considered a "protector" in a detoxifying diet?
- A. Calcium
 - B. Manganese
 - C. Phosphorus
 - D. Vitamin D
7. Oxygen free radicals :
- A. are tertiary toxins
 - B. are produced by the liver after detoxification enzymes are exposed to a substance of abuse
 - C. can result in damage to the nervous system
 - D. are neutralized only by intake of zinc, carotene, and Vitamin E
8. Substance abusers
- A. should consume dairy products daily if they are using a nutritional detoxifying diet
 - B. rarely run the risk of altering their cognitive behavior
 - C. may contract eczema due to an increased toxic burden caused by an alteration in their immune system
 - D. tend to have stronger intestinal linings than non-substance abusers

Directions in Mental Health Counseling

VOLUME 3 • LESSON 3

“Repair” vs. “Growth” Approaches to Therapy

Paul L. Adams, MD

Dr. Adams, Emeritus Professor of Child Psychiatry, University of Texas Medical Branch, Galveston, TX, and Visiting Professor of Child Psychiatry, University of Tennessee Center for Health Sciences, Memphis, TN, maintains a private practice in Louisville, KY.

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Editor's Note

In this deceptively simple presentation, the author discusses one of the central controversies surrounding the practice of psychotherapy today. On the one hand, advocates of a strict medical model of mental illness stress the importance of accurate diagnosis and the need to use whatever forms of treatment promise to provide patients with relief of pain and restoration of function as quickly and surely as possible. This philosophy is inevitably fueled by the exploding cost of health care. It also appeals to common sense and meets the necessary requirement of establishing sound approaches to the education and training of practitioners to assure acceptable levels of quality and professionalism. On the other hand, from Jung to Maslow, the experience of becoming mentally and emotionally distressed has also been viewed as a singular opportunity for individuals to undergo profound psychic changes, sometimes bordering on transcendence, but in most instances containing a promise that through therapy, one can become not just well, but more human, more actualized, and psychologically richer than before.

In truth, experienced therapists have long since learned to integrate both the repair and growth philosophies in their treatment of many clients. How each client views what he or she is going through...illness, treatment, recovery...inevitably shapes the course that therapy takes. There is no way that the average client can ever "go home again." He or she *must* be changed for what they have gone through. It seems to me that the restoration of morale (so central to recovery), hope (recovery's energy), and the reduction of shame require that therapists and clients alike view treatment as an opportunity for growth, rather than simply a way to cure an illness.

Introduction

Psychotherapy is best understood today as one of several modalities that can help our clients. Wondrous claims made for psychotherapy are more modest today than they were a half-century ago. Today our outlook is more pragmatic and realistic. As a vital part of a multimodal treatment regimen, psychotherapy can make valued, unique contributions to the overall program, but psychotherapy today is only part of the entire therapeutic spectrum.

Those who deny that psychotherapy may play an important role appear to have become less strident and less numerous. Many honest and effective clinicians now acknowledge psychotherapy's efficacy in helping their clients alleviate personal distress, restoring their morale, improving their interpersonal relations, and adding a worthwhile dimension of personal growth. Little remains, apparently, for serious debate on this score by adopters of a biopsychosocial model.

Repair versus Growth

The debate within psychotherapy and among psychotherapists over symptom removal versus personal reorientation or recommitment may endure, however, and this debate merits our consideration in this lesson. The person who adopts the client role appeals to a therapist for help in solving a variety of problems—in changing what they do, think, or feel—and the therapist aims to aid them in functioning better. For most, a reduction of their symptoms of distress, such as fear, loneliness, dysphoria, emptiness, or pointlessness, is what they long for. Freud, therefore, held the sensible opinion that any treatment that left a person feeling better was good treatment.

Certainly, symptom reduction, if only by reframing the problem, is also the intent of all forms of psychotherapy, whether cognitive, behavioral, or expressive. Viewed mechanistically, symptom reduction is a repair job. The quicker, the better. There is a place for that.

If we see the repair and growth poles at opposite ends of a psychotherapy spectrum, we may view the situation aright. But we should not forget that there is a possibility that the relation between repair and growth is not a linear and bipolar one but instead a circular and spiralling spectrum, with the seeming contraries encircling and overlapping each other at the very moment that they may strain to be most distinct and differentiated. Hence, Jung could try to snap his client back to reality at the very moment that, with Jung's encouragement, he or she had taken flight into the highest excesses of fantasy. Such ascensions and descents are built into many psychotherapies. There may be no sharp demarcations of repair and growth as goals in psychotherapy.

Repair Therapy

Nine characteristics of repair therapy can be distinguished: fault-centered, limit-setting and controls, postulated homeostasis, change viewed as realignment, use of a mechanistic paradigm, variety of views about humankind, realistic goals and standards, aims of social acceptability, and regularized training for its practitioners.

FAULT-CENTERED:

Repair therapy is **fault-centered** or problem-oriented. People with human troubles, like those with malfunctioning automobiles, have a place to go when something needs to be fixed—in this case a therapist, who can make a sensible evaluation of

what needs fixing, and then proceed with rational steps to solve the identified problem. The auto mechanic does focused work, usually leaving undone whatever is extraneous to the problem at hand; perhaps even peripheral work is omitted or neglected as a result of task-centering, of the focal scrutiny being directed exclusively on what needs to be fixed. A good auto mechanic may warn of other observed difficulties but will let them go until later.

The repair therapist, taking a problem-oriented approach to a client, would attempt to size up the problems and weaknesses rather quickly to identify the main difficulties the client has, and then would work in the sector of those problems as expeditiously as possible.

Psychiatrist and anthropologist Arthur Kleinman (1988) has criticized the current-day therapeutic preference for observable behavioral *signs*, while neglecting *symptoms*. He notes that neo-Kraepelinians, the biological therapists of today, posit that whereas signs will point the faithful to a disease in its biological substrate, symptoms only point to sociocultural idioms of distress and are regarded as more subjective and less "real." Kleinman knows that an illness is often present when no disease exists; he writes about psychotherapy cross-culturally, and he largely employs a "growth" perspective.

The repair-oriented therapist gives top concern or priority to those problems that could be called signs, but does not balk at putting some subjective symptoms onto the worklist.

LIMIT SETTING AND CONTROLS:

Repair therapy is cognizant of, and uses, limits and controls. It seeks brevity rather than interminability, so it can stop at less than a thorough overhaul. Repair work sets realistic goals, gets on with what is called for, and takes periodic stock of the progress made. Repair work is usually cogent, accountable, and cost-effective service.

POSTULATED HOMEOSTASIS:

Repair therapy shares a widely held and widely revered view of humankind in which a person is, as the automobile he or she drives, a generally sufficient homeostatic system—a vital balance—that goes through unbalancing crises at times but returns then to a steady state, or at least a *steady-enough* state. The repair therapist's only metaphor is of a slightly haywire machine that lives nearest its essence when not a bit haywire or worn, but nearly perfect and running smoothly. The repair therapist would not be restrained in taking a history of the onset of the disorder, in examining the chronology of the symptom progression, and in exploring with the client what the meaning might be. However, if the picture was of recent onset, a new episode of disorder rather than chronic, the repair therapist might hope that the disorder would resolve quickly. Indeed, many human stresses and strains (crises) can be reequilibrated over a five-or six-week period, provided clients have a chance to spill out their anguish to a good listener, one who is expert in crisis intervention. If the symptoms worsen and the time of crisis runs out, as often occurs when a repair therapist is optimistic about quick relief, the repair therapist would begin to have reservations about the prognosis; but in his or her higher moments, the repair therapist would be optimistic that a timely rebalancing and repair could be effected.

CHANGE VIEWED AS REALIGNMENT:

Repair therapy has one particular outlook toward change. It considers all change to be more apparent than real, a reshuffling of the same old deck of cards. Repair therapy subscribes to a philosophy of gradualism, which rejects conversion, sudden rebirth, or profound and enduring change. What is envisaged is basically the notion of change on a continuum. Indeed, Freud condemned therapeutic zeal—*furor sanandi*—and preferred dull, habitual reasonableness. In the repair approach, not much change is called for and change, after all, is not a dangerous swaying;

it is a waxing and waning, certainly, but never very radical. Changes are said to be made always according to a prescribed and predictable pattern. If a client can become a mite better, losing the more florid signs and symptoms even if retaining character or personality problems, that may be progress enough in the opinion of a repair therapist.

USE OF A MECHANISTIC PARADIGM:

Repair has a preference for interactions which fit a mechanistic, morbidly rational, and highly cognitive paradigm. It is almost as if a little science can be made to appear formidable by the choice of a vocabulary derived from rational mechanics. Insight is often the goal in one major school of repair therapy, but insight-seeking therapy will seldom specify how insight betokens a personal change, a reorientation of the person. Indeed, well-treated, insightful people are rarely made more loving than, or otherwise very different from, their pre-therapy state because a hard-core narcissism endures, an "unlived life that kills," as the poet Rainer Maria Rilke termed it. The repair approach may content itself with seeing alterations only in the realm of the intellection and reasoning.

In the 1940s, a reconciliation between behaviorism and psychoanalysis was thought to be imminent. John Dollard, Franz Alexander, and many other therapists and behavioral scientists participated in that hope. Truly, both schools held to a common mechanistic-materialistic base, so why should they not join together and integrate? But why the hoorah? In both behavioral and psychoanalytic therapy, the therapist is steeped in insight and filled with notions, but only in psychoanalysis is the client expected to partake of the therapist's ideologic feast. It was only during the 1960s that humanistic psychotherapy began to call down a pox on both their houses and declare itself a "third force." Of course, there were forerunners, and Bruno Bettelheim even declared Freud to be more humanistic than his translators, the Stracheys, wanted him to be. Surely, Adler and Jung, but most especially Otto Rank, foreshadowed humanistic psychotherapy by decades.

VARIETY OF VIEWS ABOUT HUMANKIND:

Repair therapists do differ among themselves about the nature of knowing the human machine. One school, behaviorism, claims the knowable machine is completely and exquisitely bound to its surroundings and to environmental contingencies. Behavior, says the behaviorist, is so governed by its environment that only a fool would attempt to speculate about what occurs within the black box attached to the machine. A second school, psychoanalysis, says, "Nay, brothers, the machine's very controls are in the black box!" To psychoanalysts, the machine as a whole, including the part boxed off from awareness, is fully comprehensible; it follows laws, it is pre-programmed; it is impelled by Eros and Thanatos. It is all orderly arrangement—of id, ego, and superego—of basic conflicts and defensive maneuvers. Self-concept and self-system receive nods of approval, perhaps, but self-transcendence warrants only a perplexed look from many psychoanalysts.

REALISTIC GOALS AND STANDARDS:

Repair therapy does have some realistic goals and standards that are distinctive to it as "scientific" work. Its first rule is to do no harm as it goes about diminishing abnormal signs and painful symptoms. A second rule is to immunize or protect the client against future outbreaks of the disorder. A third rule or goal is to bring about a genuine reorganization or recommitment of the personality. It is to the credit of psychoanalysis that that big step is made, from immunization to personal reorientation. Behavior therapy, by contrast, pooh-poohs the very idea of undertaking all that work because, behaviorists insist, symptomatic relief is good enough. Or, symptomatic relief has ramifications that may bring about considerable restoration of morale, as evidenced by positive self-evaluations once the symptoms are gone.

How one gets from immunization to genuine personal reconstruction in the repair approach is usually not specified. Oftentimes, the ideal of profound personal change is not even explicitly sought; an overhauling and reconditioning is good enough, ambitious enough. A good overhaul readies the machine for effective performance, for a better adjustment to conventional life with fewer pangs from both inner suffering and being different. Some repair-therapy clients, of either a behaviorist or psychoanalyst, actually view the whole process as a kind of spectator sport: it is interesting but not very engaging or upsetting.

AIMS OF SOCIAL ACCEPTABILITY:

An eighth feature of repair therapy is that it aims for the client's greater acceptability and, as a corollary, for the client's greater sense of belonging—with heightened sociability and Adlerian *Gemein-schaftsgefuehl*, a feeling of sociability. Group therapy often expresses this last characteristic most fully among the repair therapies. Nathan Ackerman was the first of the family group therapists to set up the aim of an augmented capability for loving relations, thereby enshrining intimate sociability. To give it its due, such a repair therapy approach does restore some sense of "roots" to the alienated, downtrodden, exploited, and lonely people of this world. Not a bad attainment.

REGULARIZED TRAINING FOR ITS PRACTITIONERS:

Reparative therapy, being rationally problem-oriented, has a ninth and vital trait: it leans toward disciplined, regularized training for its practitioners. Discipleship and sturdy apprenticeship are stressed as the ways to become professional, which means that therapy training inculcates knowledge, skills, attitudes, minimum standards of good practice, and a code of ethics to govern its practitioners both while they are in training and later when they are full-fledged, "qualified," professionals. The entire

repair outlook diminishes "wildness" and to some may seem overly rational, reminiscent of a guild-doctrine or a bureaucratic style.

Clients need whatever advocacy might be accomplished in their behalf, whatever protection, whatever security. They certainly should not be exposed to charismatic quackery by someone who is not rather stably situated in the local community and thus held to the canons of accountability. Because repair therapy claims to be scientific, it is probably more cautious and thus more likely (than some of the fly-by-night growth therapies) to provide that kind of consumer protection.

Growth Therapy

In contrast to repair therapy, growth therapy focuses on the client's potential for self-actualization as well as working towards relief from suffering.

ACCENTUATING THE POSITIVE:

Growth therapy underlines the positive aspects of clients, as exemplified by Frederick H. Allen, a Rankian child psychiatrist who never dwelled on the snags and setbacks.

The assessment of strengths and coping skills is stressed in growth therapy.

Assets are ferreted out as much as weaknesses or liabilities. Even contained in neurosis, say the existentialists and Rankians, we can find some constructive or healthy tendencies that just missed the mark and so became crystallized as neurotic formations.

In emphasizing the positive attributes of a client, the first growth therapy postulate is not too unlike one of the major tenets of one kind of repair therapy, namely behavior therapy, which asserts that it is **easier to reinforce preferred behavior than to extinguish undesirable habits**. That seems to be a sound psychotherapeutic doctrine in many schools of psychotherapy.

Some clients' assets are so numerous that they easily come to dominate the clinical picture. Intelligence, good ego strengths, a basically favorable picture of self,

and very zesty fantasies, dreams, imagery, and appetites—"id strengths"—awaiting liberation, are all delightful client assets that make most therapists happy in their work.

OPENNESS AND FLEXIBILITY:

Growth therapy is rather hesitant to aim for cures, to project a goal of results that are analogous to recovering from a bacterial disease. Indeed, all charting and planning may be rejected. The medical aspect of psychotherapeutic work is minimized.

Some of Rank's technical contributions, such as seeking brevity or setting up an endpoint in advance in order to establish bounds and limits for the work to be done, were not in the spirit of growth therapy but instead of repair therapy. The range of reactions to Rank's end setting has been interesting: Alexander and others gave Rank a favorable review on these innovations (of course, only after Rank had died). Clara Thompson, however, doubted that such technical novelties would be a lasting part of the Rankian heritage. Many today agree that contractual and brief therapy is here to stay. A purer growth therapy attitude would not have preconceptions about endpoints and schedules, but instead would nonchalantly see the needed work as requiring from 3 to 4 hours to 700 or 800 hundred hours—showing a Zen-like indifference to time and effort.

AN OPEN SYSTEM:

Growth therapy has its specific anthropology, viewing the human condition as a very open system—often as a system blown open—but sometimes as hardly a system at all, because of its extreme openness. Growth therapists conceive of the human being as capable both of steady habit-forming *and* of unequilibrated flukes, surprises, and *satori*. A growth approach makes room for the universe to be made of cinders, not geometric patterns, and makes allowances for cataclysm, not gradualism. Growth therapy respects the language of myth as well as the language of games and

propositions and commitments. Growth therapy, as described by Maslow, sees the human being as a pilot, not a robot. Many growth therapists, from Horney to Rogers to Maslow—but not including Rank or Adler—have subscribed to a Rousseauian belief that there is something basically good within us all that impels us toward the fulfillment that a therapist merely facilitates.

Growth therapy's attitude toward a client tends to be highly empirical, relying on experience alone, working out no preconceived formulas. Instead, it waits only for a "holy spirit" to guide the transactions of the precise moment then and there. In actuality, such an approach is often difficult to attain. Yet adopting some of the growth therapy viewpoint makes it possible for a therapist to react at some moments in ways that hold important meaning for both client and therapist.

VITAL INSTEAD OF MECHANICAL CHANGE:

Psychotherapy with a growth perspective rejects mechanism and leans toward vitalism. It dispenses with counting and quantifying, and it has no affinity for positivist notions or petty science. The growth perspective is more functional, asking not "What was it?" but "To what ends was it done?" The growth perspective is much more centered on the feelings themselves than on any rational summations about feelings. The growth perspective values understanding more than knowledge.

A true hazard is present when the growth perspective inclines therapists toward mindlessness or demeans the import of hard work and serious application. A Rankian social worker once told me that a supervisor had warned her, "Don't assume that you can feel your way through life!" Since we do, in many ways, feel our way through life, her supervisor was mistaken, of course, but correct in advocating that many faculties other than feelings have some uses, too. The growth perspective's emphasis on guts, or emotions and unvarnished will, might overlook elements of no less critical value.

DANGER OF SOLIPSISM:

Still another hazard of the growth emphasis needs to be discussed: its risk in what Benjamin deMott called "a glorification of a particular view of the self." He referred to the view of the self as not just the final arbiter on truth and reality but as the **only** arbiter. The self may come to be quite narcissistic, grandiose, overriding, and negating history, sin, or any previous moral learnings. The comments of another person are discredited by such a view of the self, "for you are not me and therefore cannot begin to understand what I perceive."

VALUE OF THE TRUE SELF AND SELF-TRANSCENDENCE:

The growth emphasis in psychotherapy seems most salutary when it accepts the power of feelings and fantasies and the forcefulness of verbal constructs on human living but moves onward to penetrate to the depths of selfhood so as to confront one's **true self**. In those depths of authenticity, a person can move beyond roles to self-transcendence, and not bask in the delights of self-centeredness.

A GOAL OF PROFOUND CHANGE:

A growth emphasis in psychotherapy seeks all the goals of symptom reduction, immunization, interpersonal aliveness, and personal reorientation adopted by repair therapy but adds to it self-actualizing transcendence. Growth therapy might ignore the supposed hierarchy or sequential arrangement of goals that some repair therapies advocate strongly. As an example, a growth focus may lead to an exploration of character prior to unearthing a neurosis and not hold that character analysis has to wait until neurosis analysis has been completed. Both Adler and Rank, later joined by Reich and Horney, asserted that character matters (even narcissistic character trends) need not await the resolution of neurotic problems; if longings and cravings are clearly identified, character blocks may be tackled head on, early, and

boldly. A person's will, when not other-directed, or in the service of subordination or domination of fellow beings, but instead in good attunement with the deeper longings of one's true self, can produce powerful changes.

FOCUS TOWARD INDIVIDUATION:

The growth therapy emphasis shows a greater concern for individuality and uniqueness than for sameness. Growth therapy does not question the fact that we are all alike in important respects, and that we are united by cultural ties to a subspecies of people who are very like ourselves. Still, growth therapy chooses to dwell on the issue of individual differences and the ways in which individuated beings conduct a struggle as each grows and changes. Because the matter of struggle is seen as a needed ingredient of change, experienced growth therapists are not all fatuously optimistic.

A shadow, in the Jungian sense, does accompany the individualistic growth emphasis: a sentimental romanticism vaunting Faustian man so torn and so pathetic, so pathos-riddled. That can easily become absurd and banal. Another human pitfall besets growth therapy: the tendency for people who are not widely experienced and widely read to feel that their discoveries are unique, original, and creative. Only naïveté gives such pseudo-originality the room it needs for staying alive. If we overdo the uniqueness of each of us, we can begin to disrespect differences and even adopt authoritarian attitudes.

TENDENCY TOWARD ICONOCLASM ABOUT TRAINING:

The growth emphasis, whether it is in behavioral or holistic medicine, Gestalt therapy, or encounter groups, unfortunately leans toward iconoclasm about the training required of its practitioners, facilitators, or consultants. The growth focus belittles formal training and sometimes calmly tries to reassure us that wildness in a therapist is a real boon. If we worry about therapeutic casualties from est or

casualties from est or Esalen or Rolffing, we are told that going mad can exert a cleansing influence on a rigidly armored character.

For both the guru and the disciple in some of the pop-growth therapies, there is a risk of escalated shopping for a series of weekend marathon encounters to revitalize oneself, rejuice one's life, and recharge one's batteries. Why do some growth movement enthusiasts get locked into a compulsion to repeat their contrived growth weeks or weekends? Because, I think, they burn out quickly and often. An old-fashioned psychoanalysis may do them more good, one surmises.

Sacha Nacht (1962), the Parisian psychoanalyst, knew that training and discipline were essential for, not obstacles to, real growth. The analyst can be authentic without being crazy, Nacht wrote, in a spirit that made his psychoanalysis closely akin to some more moderate growth therapies:

And it can only be so if the analyst possesses an open-heartedness as nearly perfect as possible, arising above all from his unconscious, enabling him to be spontaneously and intuitively what he should be at any given moment in the actual analytical situation. His attitude should respond to the immediate ongoing process, then, and should not have been premeditated. It is in this regard so necessary that the analyst, himself the sole instrument of his technique, should possess a disposition of openness and flexibility. This will enable him to work within the indispensable framework of technical principles and yet create from the analyst/analysand dialogue a living relationship between one particular person and other. (p. 208)

Is Synthesis Possible?

Repair and growth can coexist peacefully. That they can work together does not deny, however, that they are really different. The dialectic process can lead to new syntheses. I prefer growth as the major thrust, with an emphasis on discovering the true self. But I believe that some of the excesses of growth therapy can be nicely countervailed by some of the rationality of repair therapy. For one thing,

it does not escape me that the world's children have a great need for simple repair. Repair is a good beginning and it may be "good enough" for huge masses of children. **No therapy by itself is ever enough.** As Maslow said, better nutrition and housing must precede self-actualizing. Furthermore, the world's children have a crying need for security, sociability, and acceptance or belonging—for communion. In addition, repair work may be a valid precondition for growth in many individuals. The polarized approaches can be conjoined.

Would it not be a felicitous conclusion, for all of our clients, if the two poles (of growth and repair) should wind up harmonized, converged, and overlapped...if the dialectic of repair versus growth should play itself out and emerge into a new synthesis? **That might make the ways of growing more assured, more predictable, more easily taught and transmitted.**

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Questions Based on This Lesson

9. According to the author, psychotherapists engaged primarily in "repair" therapy focus primarily on all but one of the following issues:
 - A. Rapidly identify the client's chief difficulties so as to plan approaches to resolve these quickly and expeditiously
 - B. Envision the client's distress as an opportunity for him/her to discover, through therapy, a new and higher level of homeostasis and greater meaning in life.
 - C. Restore clients to their previous level of homeostasis, thus permitting relative comfort and functioning
 - D. Do no harm while helping clients learn ways to protect themselves against future outbreaks of their disorders.
10. What the author calls "repair" therapy:
 - A. Is visualized as a long-term effort designed to produce major personality changes
 - B. Employs *only* biological treatment methods
 - C. Lacks realistic goals and favors intrapsychic exploration rather than the relief of painful, incapacitating symptoms
 - D. Leans toward disciplined, regularized training for its practitioners
11. Which of the following statements is correct?
 - A. Behavior therapists maintain that it is easier to reinforce preferred behavior than to extinguish undesirable habits
 - B. Growth therapy has a preference for interactions which fit a mechanistic, rational, highly cognitive paradigm
 - C. Intellectual insight is all that is ever required to guarantee relief of symptoms and sustained improvement
 - D. Glorification of a particular view of the self is never a hazard in the practice of "growth" therapy
12. Growth therapy:
 - A. Strives to achieve therapeutic goals as briefly as possible
 - B. Makes assessments of coping skills secondary to pinpointing problems and weaknesses of the client
 - C. Hesitates to focus on cures
 - D. Rejects vitalism, leaning instead toward mechanics

Directions in Mental Health Counseling

VOLUME 3 • LESSON 4

Marriage and Family Therapy: Theories and Applications

Stanley C. Feist, PhD

Dr. Feist is Emeritus Professor of Psychology, The State University
of New York College of Technology, Farmingdale, NY.

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EDITOR'S NOTE

When one considers how established marital and family therapy are today and how obviously valuable these approaches can be, it's a wonder that it took so long to develop the concepts and strategies that made such therapies possible. There's an old saying that to make room for new knowledge, a lot of unlearning and relearning has to take place; nor are professionals of any field known for their receptivity to novel ideas. No doubt the idea that emotional and mental disturbances were largely intrapsychic and could best be conceptualized and treated within the framework of psychoanalysis delayed the acknowledgement of the obvious fact that no man is an island and that what any individual experiences is invariably influenced by and influences everything and everyone around him.

In this lesson, Dr. Feist presents the historical evolution of marital and family therapy—from the early work of Harry Stack Sullivan and Freida Fromm-Reichman, to Don Jackson (homeostasis and working with the whole family), to Murray Bowen (children as well as parents should be included in therapy), to Jay Haley (using Erickson's directive therapy to unbalance the family system so as to restructure it), to Salvador Minuchin (using structural therapy to reestablish emotional boundaries between family members that ultimately determine the functionality of the family).

Dr. Feist summarizes the various theories and approaches to family and marital therapy. One question that remains to be answered, however, is what criteria can be used to determine whether marital and/or family therapy should be the treatment of choice, should be ancillary to other therapies provided on an individual basis, or should not be (necessarily) employed at all. Marital and family therapies have brought so much to the field that their effective application and integration with other treatment modalities deserve very careful consideration.

Introduction

Marriage and family therapy is a rapidly growing discipline. Membership in The American Association for Marriage and Family Therapy (AAMFT), founded in 1942, has increased 500% in the past 10 years (Piercy, Sprenkle, & Associates, 1986). This demonstrates the **increasing popularity of a treatment modality that was virtually unknown 40 years ago.**

From the very beginning, marriage and family therapy has been a **multidisciplinary field**, drawing members from the ranks of social work, psychology, psychiatry, nursing, pastoral care, and mental health counseling. Their varying perspectives have given strength to the field. At the same time, the diversity of professional publications has made it difficult to coordinate the collected knowledge.

Social workers must be credited with early recognition of the importance of treating the family. In addition, Alfred Adler and his student, Rudolph Dreikurs, did early work on child guidance and family treatment in the 1920s (Nichols, 1984). They worked in a team, psychiatrist-psychologist-social worker, with a focus on the child's family environment. Marriage counseling centers began to emerge in the early 1930s in several major U.S. cities; however, they generally saw only one member of the couple (Thomas, 1992).

Whereas the early psychoanalysts used a medical model of linear causation of emotional disorder, Harry S. Sullivan, working with schizophrenic clients, emphasized the importance of the hospital "family"—the nurses, attendants, and aides—as a substitute family. Freida Fromm-Reichmann (1948) also realized the importance of the family in the development of disorders, but neither of them carried their idea through to involve the family of origin in actual treatment.

In 1931, J. Moreno (1945) provided one of the earliest approaches to group therapy with psychodrama, in which participants acted out family problems. A little

later, John Bowlby (1949) used family meetings as a factor in therapy but only as an auxiliary part of the treatment at the Tavistock Clinic in London, England.

The Palo Alto groups can justifiably claim to be a major factor in the development of family treatment. Gregory Bateson's Project for the Study of Schizophrenia began in 1953 at Palo Alto and involved Jay Haley and John Weakland. The following year, Don Jackson and William Fry joined them. The Bateson group published *Towards a Theory of Schizophrenia* (Bateson, Jackson, Haley, & Weakland, 1956), which included preliminary thoughts on the "double bind" theory, and later a more conclusive work on metacommunications in the family of a schizophrenic (Bateson, Jackson, Haley, & Weakland, 1963).

In 1959, Don Jackson founded the Mental Research Institute and was primarily interested in treating families with problems. Jackson worked at various times with Virginia Satir, John Weakland, Paul Watzlawick, and Jay Haley. Jackson (1954) published the paper entitled "The Question of Family Homeostasis," in which he first describes the move toward balance or homeostasis when a family feels threatened. Later, Jackson and Weakland (1959) further demonstrated how clients' symptoms maintained equilibrium, even if maladaptive, in their families.

Also working with a schizophrenic child at about the same time was Murray Bowen, who arrived at the conclusion that both parents of the child needed to be included in the therapy to detriangulate, or clarify the emotional relationships within the family (Bowen, 1961, 1978). This led to the development of a didactic therapy intended to clarify and define relationships between the parents and help each family member take a responsible stand for his or her convictions. Bowen struggled to remain impartial and separate from the undifferentiated ego mass of the family. He forced the family members to solve their own problems, thereby becoming more stable and dependable.

The Child Guidance movement was also influential in the development of Family Therapy (Ginsberg, 1955). Child Guidance was originally supposed to prevent the occurrence of serious problems in children. It was soon evident that the child, although armed with proper knowledge, was still helpless before the powerful emotional forces in the family. The next step for many therapists was to include the mother in the session. It then became apparent that the mother's behavior toward the child was influenced by the relationship between the mother and the father, and the circle of influence enlarged.

Nathan Ackerman applied psychoanalytic thinking to family therapy. He began using the prevailing child guidance model in which the therapist treated the child while a social worker dealt with the mother. In the 1940s, he began to see both the child and the mother and then went on to include everyone in the household in the treatment sessions. Psychoanalytic trained, Ackerman was always aware of the individual's inner needs and emotions (Hoffman, 1981). His *Psychodynamics of Family Life* (1958) is considered by some as the establishing document of family therapy.

Currently Jay Haley and Cloe Madanes teach and apply their version of communications theory—Strategic Family Therapy. Haley (1963) describes how he uses Milton Erickson's directive therapy by assigning a task designed to unbalance the family system so that it may be restructured in a more efficacious manner. Paradoxical prescriptions are part of this treatment.

Another contemporary therapist is Salvador Minuchin. His structural therapy (Minuchin, 1974) is designed to reestablish the emotional boundaries that determine the closeness or distance between family members. Minuchin looks at the enmeshment or disengagement present in dysfunctional families and works to restructure dysfunctional boundaries.

Several therapists from Italy have contributed a great deal to the field of marriage and family therapy. Among them are Maurizio Andolfi (1980), who studied with Minuchin and who uses strategic and structural concepts along with paradoxical interventions in an attempt to reorganize family interaction.

Mara Selvini-Palazzoli (1978) of the Milan group reportedly commented, "Family systems is a way of thinking, not a garage for repairing families." Palazzoli, along with Luigi Boscolo, Gianfranco Ceccin, and Guiliana Prata, developed a unique approach to working with families.

Other significant contributors to marital and family therapy are Ivan Boszormenyi-Nagy with Krasner (1986); Duhl, Kantor, and Duhl (1973); Lynn Hoffman (1981); Peggy Penn (1985); Virginia Satir (1983); Lyman Wynne (1988); and Carl Whitaker with his provocative psychotherapy of the absurd (1975). Time and space limit the great number of outstanding family therapists who should be mentioned here.

The Conceptual Development of Family Therapy

LINEAR VERSUS SYSTEMS THINKING:

Most traditional psychotherapies are based on the medical model of linear causation of disorders. If you have a sore throat, the problem is caused by a bacterial infection of the mucus membranes of your throat. In the emotional analogue, if a person is immoral and unethical (in other words, a sociopath), the problem probably stems from improper acculturation, lack of superego development, or some specific cause, depending on one's theoretical viewpoint. **The linear view is grounded in the concept of a particular cause or causes for a specific disorder (Nichols, 1984).**

Emotional and behavioral problems are seen as caused by some prior event, learning, or disease. This is linear thinking.

If someone has a problem, it must be something inside that person or that person's particular way of perceiving situations. It has always been evident to individual therapists that family influences were important in shaping personalities. However, it was considered that the person's internalized view of childhood events was the more dominant influence. Often the client was separated from his natural environment and treated in isolation from the family in order to rearrange his inner patterns. Sometimes interpersonal contact with the family would be absolutely forbidden. Although linear treatment may alleviate or reduce the symptomatic behavior in the individual, the family was expected to readjust, with the symptoms exhibited in another manner by another family member.

SYSTEMS OR CIRCULAR THINKING:

The concept of circular causality may offer a more meaningful explanation of many disorders (Thomas, 1992). Circularity examines the interactions among all the participants in a situation and may consider the internal system of an involved individual as well. Causality is circular in systems thinking. When one family member does or says something, that action is a stimulus for another family member to respond. The response stimulates additional interaction between the same or other family members that continues in a circular manner (Hubert & Hubert, 1986). Because the family therapist believes that the current daily influences of the family are the significant factor, the family must be seen in therapy as a group to rearrange these external forces in the here-and-now.

Basic to all family theory is the concept of the family as a homeostatic system. The troubled person in the family, often called the "identified patient" (IP), bears the

symptoms for family dysfunction. The symptoms are viewed as a functional way to maintain homeostasis. Intervention in the system will require an adjustment for the family if it is to retain the homeostatic balance. The task of the therapist is to intervene in such a way that a new balance can be achieved that does not include the maladaptive symptoms. Inappropriate intervention allows restabilization without change; the symptoms continue. The systems approach views the symptoms as functional, but maladaptive.

Family therapy was modeled after group therapy and based on concepts of group dynamics, specifically the understanding that groups are more than the mere sum of the personalities involved. Processes emerge that are the product of the interactions of the cluster of personalities. Group therapists realized that the best results were often obtained by considering both group dynamics and the inner dynamics of the individual. Most family therapists continue to use some group therapy methods as means of promoting interactions among the family members.

The concept that the psychopathology in the family had a function provided another step in the development of family therapy. Freud, in his *Psychopathology of Everyday Living* (1901, 1960), takes note of the purpose served by psychopathology in the individual. Further, studies of schizophrenic families demonstrated that the deviant behavior of a child often triggered a negative feedback loop that helped maintain family togetherness. Thus, the deviant behavior was maladaptive for the child's individual functioning but provided an adaptation for the family structure. This explains why another family member would develop symptomatic behavior when the behavior of the first IP began to be less symptomatic. For this reason, the IP and the family as a unit are likely to exhibit behavior that tends to be rigid and inflexible. They fear losing whatever function they do have (Jackson & Weakland, 1959). Jackson coined the term "family homeostasis" (1954) for a family's reluctance to change. He

described other families as a "runaway," with an increase in deviant behavior that increases the stress and thus creates a need for change to occur. Whitaker and Minuchin have also noted that stress and crisis in a family create a condition whereby restructuring is more likely to occur to reduce the discomfort.

We see here some of the essentials for thinking about family functioning as a system of behaviors in which any one action influences the behaviors of others. A circularity of interaction exists in any group situation, and intervention at any one point can change the whole system. This is the basis of systems theory as applied to therapy.

The two basic views of a system are as a cybernetic or closed mechanistic system, or as an open system. The closed system uses self-regulating feedback loops, as in home climate control: a thermostat causes the heating or cooling system to turn on or off because of a simple change in temperature. In the normal course of events, nothing else can operate that system. This is a goal-seeking system, with maintenance of a constant temperature as the goal. The analogy, however, is somewhat of an oversimplification; there is oil and/or electricity as an energy input from outside of the system and human adjustment to keep everything in proper function.

The general or open systems theory seems to offer a more useful explanation when examining human family behavior. People are not like machines; they are interactive and creative. They are affected by and actively influence their environment, with an active interchange of materials, energies, or information with the environment. The system behaves as a whole; change in any one part alters the whole system. This theory offers a completely new way to view and to alter what is usually considered to be maladaptive behavior. Once the therapist can discover the special purpose of the symptoms, it becomes possible to replace the maladaptive family behaviors with other behaviors that are more functional.

A healthy, functioning system accepts feedback, is flexible, and is open to change. **A poorly functioning family system is involved in preserving family homeostasis at all costs; it uses feedback to maintain an unhealthy stability and resists change.** This concept of system functioning can be applied to one person as well as to a family or any larger organized whole. It may not be necessary to give up the traditional ideas of psychoanalytic insights for the individual, yet **one must be extremely careful not to slip into the linear mode when the circularity of the family is not readily evident.** This is especially important when one has been trained initially in some aspect of psychodynamic theory.

No matter what the specific theoretical preference of the therapist may be, symptoms in any one member are seen as functional to the family systems organization, restoring stability by expressing and deflecting family tension. Papp (1976) outlined the following basic systemic postulates:

- The family is viewed as a whole, greater than the sum of its parts or members.
- Each member's behavior can only be understood within the context of the family unit.
- Change in any one member of the system will affect all other members of the system.
- The family regulates itself through feedback loops (cybernetic circuits), which provide balance (homeostasis) to the system.
- No one event linearly causes another to occur. Rather, behaviors are parts of larger circular patterns that recur over time to balance the family and permit it to move through various developmental stages.

The circular approach does not perceive symptoms as disease but rather as a maladaptive attempt on the part of the organism to maintain a comfortable state of function. For example, alcoholism probably began as an attempt to relieve stress and pain but somehow got out of hand; neurotic behavior is considered to have been

designed to adapt to an emotionally charged situation but became exaggerated and developed into impaired functioning.

Usually the family goes to therapy because one family member is showing symptoms of a disorder. Instead of viewing this person as the patient, we see the whole family as the patient needing treatment. The person with symptoms is merely the one who has been chosen to act out the disorder of a malfunctioning family system. The maladaptive states we see in a person simply reflect the intensity of the problem in the larger family system. Systems thinking may eventually give us some clues into other situations in which adaptive symptoms became the focus for a totally different problem.

Need for Theory

Early practitioners of family therapy were theorists only in the sense that they developed theories after the fact to rationalize their methodology. However, theories are necessary if the efficacy of the methodology is to be tested.

Therapists frequently are impatient with theory; they want to learn the techniques and get on with the treatment. However, techniques are the specifics and the details; they can be learned by rote but then offer only a very limited repertoire of therapeutic behaviors. Using techniques without some master plan often leaves the therapist in a confused state when the clients do not respond to the technique as planned. Theory is something better than technique, although one must also carry a large "bag of tricks." Theory offers an understanding of the master plan of family behavior, as well as an overall methodology for treatment. Having mastered the theory, the therapist is less likely to get stuck in the morass of family emotion.

Certain techniques are part of almost every family treatment process. They lead to therapeutic goals that maintain the family's sense of self and of operational

competence while challenging the maladaptive behaviors. Some of these are described by Hoffman (1981):

- *Joining* (therapist's accommodation is to win confidence and become more acceptable to the family)

Maintenance: highlighting the positive behaviors and ideas of family members—their strengths.

Tracking: following both content and process of family members' contribution to sessions, using their metaphors, asking for expansion of their ideas

Mimesis (nonverbal component of joining): responding to the affect, pace, mood, and posture of the family

- *Challenging*: confronting the family myths and its varied behavioral versions
- *Reframing* (the basic intervention of all therapies): putting the problem in terms of the client's voluntary behavior, not as a helpless victim
- *Enactment*: stimulating family interaction to observe and change transactions and structure
- *Boundaries* (both theoretical and concrete, one reflecting the other): observing an evolutionary process of negotiating boundaries and positions in the healthy family
- *Unbalancing*: restructuring by upsetting the established boundaries that the family desires to maintain
- *Interpersonal Intensity*: therapist's using of self
- *Linear Perspective*: exploring the theoretical and unreal of each person in the family as a unique, independent being
- *Interactional or Circularity Perspective*: observing how each family member influences the behavior of all other family members *ad infinitum* (the feedback loops)

Communications Family Therapy

In the early days of family therapy, a few basic theories formed the groundwork for much that followed. Communications family therapy is among them. This theory

stemmed from the work of Gregory Bateson, an anthropologist doing research on schizophrenic communications. His interest, along with that of J. Haley and Don Jackson, was scientific, not therapeutic. Bateson's observations led him to believe that interchange of messages between people defined their relationships, and these relationships were stabilized by homeostatic processes in the family. Bateson, Jackson, Haley, and Weakland generated the double-bind theory of schizophrenia by deductive reasoning; only afterwards did they see families to test the theory (Nichols, 1984).

The communications people are systems purist; they concentrate on the input and the output of the system. Families are seen as error-controlled, goal-directed systems. Family interactions are analyzed using cybernetics, general systems theory, and game theory. Although communications theories describe families as open systems, they treat them as closed systems in their clinical work.

The therapy is concentrated on the nuclear family with little or no input from the extended family or the community. Clinical attention is to the here-and-now in a non-historical approach. When parents communicate clearly in a focused, well-structured, flexible manner, their children are regarded by teachers and peers as competent both academically and socially. Behavior disorders or symptoms are seen as communicated messages, statements made by the system in an attempt to maintain the family homeo-stasis. Pathological families are enmeshed in very strong homeostatic patterns of communication that are seen as dysfunctional from the outlook of the larger society. They are inflexible and very strongly resist change; change is experienced as threatening rather than as an opportunity for growth. Lyman Wynne's concept of communication deviance shows a correlation between negative, derogatory, disparaging, and critical remarks and pathology in the family (Wynne, 1977).

The goal of communications family therapy is to identify as the symptom the message that needs to be changed, then interrupt the positive feedback loop that perpetuates that message (Watzlawick, Beavin, & Jackson, 1967). The therapist is an outsider who supplies what the relationship cannot—a change in rules.

This is similar to the linear approach of Albert Ellis's rational emotive therapy, a cognitive approach to psychotherapy. The major difference is that Ellis works with individuals, not families. The therapist can point out the offending messages or can manipulate the family in order to effect change. The first method depends on the cooperation and good will of the family; the second does not. It is an attempt to beat the family at their own game, willing or not. The general method follows from the "black box" concept of communications technology. You need not know exactly what is contained inside of your computer; you need know only what to put into it and what output to expect.

One technique of communications therapy has the family members speak only in the "I" language—not for any other member—and to speak directly to, not about, each other. Body language, posture, facial expression, gestures, and physical proximity are very important aspects of communication and are carefully noted by the therapist. All behavior is communicative; therefore, people are constantly and consistently communicating, even when no words are spoken.

Therapy consists, in part, of reframing, so that the symptoms are not perceived as involuntary. The self-fulfilling prophesies or hidden expectations are revealed to the family and then cognitively altered. The therapist rephrases and redefines the activities of family members in positive ways, allowing the family to communicate more openly and move more closely together. This is primarily an intellectual and scholarly approach, not founded upon empiricism.

The practice of communications therapy and theory, one of the first and most influential schools of family therapy, is no longer a separate school of family therapy: its concepts have been absorbed by the entire field. **Three major models of communication theory have emerged. Haley developed a model that emphasized communication and power, Jackson developed a model emphasizing communication and cognition, and Satir developed a model emphasizing communication and feeling.** Paul Watzlawick, John Weakland, Theodore Lidz, and Lyman Wynne, among other renowned therapists and theorists, had their beginnings in communication therapy and theory. All communications theories emphasize how people relate to each other.

Bowenian Multigenerational Theory

Murray Bowen was trained as a psychiatrist and as a traditional psychoanalyst at the Menninger Clinic. While doing individual therapy with schizophrenic clients, he noted the **extreme emotional "stuck-togetherness" between the mother and child.** He proposed that in human beings, **two conflicting forces coexist—one moving toward individuation and autonomy, the other toward togetherness or fusion.** He viewed the symbiosis or fusion as the intense emotional process upon which schizophrenia was later superimposed. After he had the mother stay in the hospital with the client and treat both, it soon became evident that **the fathers were equally entangled** through active support of the symbiosis or through submissive departure and isolation. A triangle had formed where there had been a primary dyad of mother and father. The triangulation may stabilize the family but may also prevent useful resolution of dyadic conflict (Bowen, 1966).

Bowen came to believe that the whole family had to be treated as a unit to bring about the desired change in the identified patient. Most important for Bowen was for the individuals to become differentiated, to individuate, to

become unstuck. Bowen suggested that emotional illness is multigeneration; that is, it has its origin somewhere in a previous generation in which the family members had difficulty separating from the family core. The feeling of stress is maladaptationally reduced by "triangling in," by involving a child (the next generation) in a symbiotic relationship. This is called fusion and results in an undifferentiated ego-mass, more recently called nuclear family emotional system. Then the child is stuck. This emotional stuck-togetherness amplifies until the disturbance reaches a point of serious maladaptation for living—an emotional disorder. The generational boundaries become blurred and indistinct. It becomes the task of therapy to reform these generational boundaries, to detriangulate the client so that the fusion is dissolved and differentiation can occur. The classic triangle is the close mother and child and a passive, withdrawn father. If the father tries to get close to his child, the mother becomes upset, afraid she will become the left-out, isolated person.

Six interlocking concepts form the basis for Bowen's theory: (1) Emotional triangle, (2) differentiation of self, (3) nuclear family emotional system, (4) family projection process, (5) multigenerational projection system, and (6) influence of sibling position.

EMOTIONAL TRIANGLES:

Emotional triangles are the smallest stable relationships in families. Relationships made up of two significant persons are unstable; when tension arises, a third person or thing is triangulated. When two lovers experience tension, one turns to a friend, a parent, a therapist, alcohol, etc. Marital conflict sometimes provides a "solution" to the dilemma. Conflictual marriages are extremely intense emotional relationships in which a period of extreme closeness is followed by a

strongly separating argument that allows each to feel justified in maintaining distance until the next cycle.

DIFFERENTIATION OF SELF:

Differentiation of self is both intrapsychic and interpersonal. Intrapsychic differentiation allows the separation of thoughts from feelings, whereas interpersonal differentiation allows individuation from significant others in the family system. Individuation is the opposite of fusion. The person who accomplishes differentiation is capable of thinking and feeling, of strong emotions and spontaneity, of rational restraint from acting on impulse.

NUCLEAR FAMILY EMOTIONAL SYSTEM:

Nuclear family emotional system deals with the forces in families that operate multi-generationally in recurrent cycles and were previously called undifferentiated family ego mass or emotional stuck-togetherness. Lack of differentiation from parents results in a child who is emotionally cut off from them. In turn, this leads to fusion in marriage for the child. The poorer the differentiation of the child prior to marriage, the greater the fusion with a spouse after marriage. This condition is unstable and may manifest itself as reactive emotional distance from spouse, physical or emotional dysfunction in one spouse, overt marital conflict, and/or projection of the problem onto a child.

The use of emotional cut-off reflects, solves, and creates a problem. It reflects the presence of an emotional fusion problem, solves the problem by creating distance and reducing anxiety, and creates a problem in that it isolates and alienates people who could benefit from each other if they were only able to relate better (Nichols, 1984).

Fusion is an interesting paradox that provides both a source of and a relief from anxiety. The more intense the emotional needs of people in a relationship, the more they look to the relationship to fulfill those needs and relieve the anxiety. However, the emotional pressures of the intense relationship forces them into compromised, uncomfortable positions—an impossible paradox.

FAMILY PROJECTION PROCESS:

The family projection process describes how the fusion of the parents is transmitted to the children. The mother believes that she sees certain insecurity in a child and behaves toward that child as if that insecurity were real. The child accepts and is molded by the mother's belief and behavior and begins to behave as the mother does. The emotional fusion—the lack of differentiation between parent and child—may be manifest as a warm, dependent bond, or an angry, conflictual struggle. The child's functioning is stunted either way.

MULTIGENERATIONAL PROJECTION SYSTEM:

The multigenerational transmission process describes how the family emotional process is handed down from one generation to the other. Clifford Sager (1976) is one of the therapists who discusses the multigenerational approach. It is his contention that dysfunctional behaviors or patterns are passed from one generation to the next in some nonverbal manner. Problems transmitted across the generations can be helped by open discussion and subsequent recognition of the situation.

INFLUENCE OF SIBLING POSITION:

Bowen (1978) concurred with Toman (1961) on the importance of birth order position. Although Toman's conclusions are not empirical, they have attracted much interest. The hypothesis states that a child's birth order position in the family

fosters the development of specific personality characteristics in that child. Bowen proposes that the family projection system may interfere with this process if a child has been triangulated between the parents. In this case, the typical characteristics may not occur. Knowledge of the general characteristics and an awareness of the family dynamics is beneficial in predicting a child's role in the family emotional process; this information is helpful in understanding and predicting multigenerational transmission of family patterns.

Bowenian Therapy Techniques

Bowenian family therapy is designed to identify the patterns that originated in the past yet have a strong detrimental hold on the clients in the present. He uses genograms to understand family relationships (Bowen, 1980); finds the fusions, the triangles, and the undifferentiated ego mass; then detriangulates to allow the family members to differentiate and foster emotionally supportive relationships that allow sufficient freedom for each family member to become a unique individual. All this is done using an analytic approach.

The therapist must be on guard to avoid becoming emotionally triangulated by a couple in accordance with the basic assumption that emotional tension between two people results in their trying to trap a third person in the emotional issues between them. The therapist needs to set the proper tone for the sessions—lively enough to be meaningful, calm and cool enough to remain objective. The therapist, using provocative questions and comments to regulate the amount and intensity of interaction, forces the couple to interact directly. Balance between thinking and feeling needs to be maintained through the therapist's control of the situation.

The interaction must not be allowed to become destructive and attacking. This

can sometimes be achieved by having each party talk to the therapist rather than to each other. In this way, couples who have not listened and heard one another for years may now be given the opportunity to listen and understand the partner. **Change requires talking plus willingness to listen.** Sometimes a point can be made by using the indirect technique of telling about another couple with a similar problem and their difficulties in dealing with that problem.

Bowen believed that every family therapist must detriangulate from his or her family of origin and be free internally of all crippling entanglements of past and present before taking full responsibility for clients. Bowen did this for himself in a clever and enterprising manner. He wrote letters to each of his family members, telling what gossip and rumors specific to others had spread to him. Then he told them when he would be coming home for a visit. He showed up as promised and had to deal with a very upset group of people. After things died down, many family relationships were better than they had been before. Bowen felt free and his family had benefitted also. In the same way that a classical psychoanalyst must undergo a personal analysis in order to understand and stay clear from destructive countertransference, the Bowenian family therapist must differentiate from the family of origin so as not to be triangulated. This is the family correlate of countertransference (Nichols, 1984).

The therapist helps family members deal with each other with a calm rationality, teaching each to state his or her own feelings by using the "I" language, thus differentiating from the family mass. After sufficient progress toward differentiation in the nuclear family has been accomplished, both are encouraged to explore, and eventually differentiate from, their own families of origin. Genograms (Bowen, 1980) are used to explore and understand family relationships. **The emphasis on extended social and family groups goes beyond the nuclear family.**

Conclusion

Marriage and family therapy is fast becoming the treatment of choice for many clients and many therapists. Many clients probably find it easier to confront a relationship problem, which they may believe is the sole province of their partner, rather than admit to a personal deficiency. Therapists find marriage and family therapy to be a dynamic, exciting, and efficacious way to work.

This lesson has been only a brief introduction to the intricacies of the marriage and family mode of treatment. Further reading includes: the psychoanalytic family therapy of Nathan Ackerman, strategic therapy of Jay Haley, structural therapy of Salvador Minuchin, behavioral family therapy of Gerald Patterson, Carl Whitaker's experiential therapy, and the many other variations of each conceived by so many creative, competent professionals. The field as a whole "is full of challenge, full of surprises and highly rewarding" (Bloch & Simon, 1982).

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Questions Based on This Lesson

13. Which of the following is *not* one of Papp's basic systemic postulates?
- A. Change in any one member of the family system can usually be successfully accomplished without affecting all the other members
 - B. The family is viewed as whole, greater than the sum of its parts
 - C. The family regulates itself through feedback loops (cybernetic circuits) which provide balance (homeostasis) to the system
 - D. No one event linearly causes another to occur
14. Which of the following family therapy techniques involves stimulating family interaction to observe and change transactions and structure?
- A. Joining
 - B. Challenging
 - C. Reframing
 - D. Enactment
15. The primary theoretical goal of Bowen's multigenerational therapy is:
- A. To improve communications among family members
 - B. To unstructure and restructure the homeostasis of the family
 - C. To dissolve interpersonal fusion and the subsequent emergency of differentiation
 - D. None of the above
16. In the communication of family therapy of Bateson, Wynne, and others:
- A. Therapy is concentrated on the nuclear family with little or no input from the extended family or the community
 - B. Therapy is focused on the extended family and the community as well as the nuclear family
 - C. Clinical attention is directed to an historical rather than a here-and-now approach
 - D. A healthy family is characterized by a high level of derogatory, disparaging, critical communications

Directions in Mental Health Counseling

VOLUME 3 • LESSON 5

Current Issues in Treating Sexual Abuse Victims

Robert H. Rencken, CCMHC, NCC

Mr. Rencken is a mental health counselor and clinical sexologist
in the Psychiatry Department of Group Health Medical Associates, Tucson, AZ.

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Editor's Note

A great deal of attention has been paid to the problem of sexual abuse in recent years and, indeed, it should be. Whether or not the experience of sexual abuse damages a child in such a way as to set the stage for the most serious psychological problems (such as multiple personality disorder), it is inconceivable that such a trauma would not contribute in some way to serious maturation problems.

By law, all professionals must report suspected child abuse. Counselors who intend to work in this area need not only broad-based, multi-modal training and experience, but specific knowledge and skills in dealing with sexual abuse itself.

Commonly used techniques for evaluation of the child victim include play assessments using toys, objects, drawing, and the like. Family therapy is the cornerstone of treatment. Various combinations of child sexual abuse phenomena seem to have different prognoses. In treatment, the so-called apology session should occur at the earliest point possible after the report while allowing for adequate trauma recovery for the victim and preparation for both the victim and offender; during such a session, a structured confrontation between victim and offender clearly allocates the responsibility for the abuse to the offender, permits a clear apology, and encourages the victim to continue in treatment. The main goal of therapy for all those involved in the event is empowerment, which not only provides healing but also addresses the issue of control over one's life.

Introduction

Even though incidents of sexual abuse, incest, and molestation have occurred for countless generations, their treatment has become a major focus of counseling only during the past 10–15 years. In that time frame, our knowledge base has exploded, with the contribution of volumes of anecdotal and research information from the disciplines of counseling, psychology, victimology, education, and rehabilitation. As a “young” field of study, much of our understanding of the problem and its solutions has come from our collective clinical experience. This experience has forged sometimes controversial issues that demand our attention and call for resolutions that contribute to our effectiveness. This lesson will focus on those issues and strategies that reflect my clinical and consultative experience.

The problems of sexual abuse, both identification and treatment, are of particular interest to mental health counselors. As the “front line” of service delivery, mental health professionals have been confronted with the direct and indirect effects of sexual abuse on children, families, adult survivors, and the systems that serve them. The counseling profession has taken (or been given) the leadership in this area, and has asked for effective strategies in assessing and treating all victims of these abusive patterns.

Current Issues

INCIDENCE:

One of the outcomes of the attention to this highly-charged problem area is that definitions and, therefore, accurate incidence data, have been varied and inconsistent. The terms incest, molestation, exploitation, sexual assault, and rape all overlap “sexual abuse” in one way or another. Although the last term is now in vogue, that may even change. Assuming a definition something like “harmful sexual contact between a child and a person of significantly greater power,” incidence estimates range

from 10%–35% for women and 10% or higher for men (Finkelhor, 1984; Hindman, 1989; Russell, 1983; Miller, Johnson, & Johnson, 1991). Such wide variability encompasses opinions that these figures are underestimates, particularly for men (Finkelhor, 1984; Lew, 1988), and those that see the reporting rate as inflated with false accusations and societal hysteria (Spiegel, 1988; Gardner, 1987). Even though some researchers attribute the increased incidence solely to increased reporting (Finkelhor, 1984), others argue that decreased family stability, economic pressures, and other societal factors would logically lead to a real increase that compounds the reporting factor (Rencken, 1989).

Regardless of the precise incidence figures, it is clear that sexual abuse is having a major impact on society. I make the following evocative statement to any audience that will listen: "Every one of you in this room has been, or will be, affected by sexual abuse—in your life, the life of your extended family or friends, or in your work." I have yet to receive any objections.

FALSE ACCUSATIONS:

In the early days of treating sexual abuse, one of the "givens" was the credibility of the child's report. It would not be unusual for trainers to assert, "Children don't lie. Period." At that point in time, that assertion may have been critically important in advancing the cause and gaining credibility in general society—finally, people in and out of "the system" would believe the unbelievable stories that children were telling.

As we gained clinical experience, we first noticed that the details of the children's stories were not matching those told by acknowledging offenders—differences in time, place, sequences, and, sometimes, behavior. We chalked it up to developmental memory issues for the child and minimization for the offender. We then noticed that some adolescents made accusations in the middle of disciplinary power struggles. Then came the "opening of the floodgates"—custody-related allegations (MacFarlane,

1986).

There is certainly an increase in abuse allegations—whether they be physical, sexual, or emotional—as a part of contested struggles (MacFarlane, 1986). Children are reported to be coached into fabricating or emphasizing incidents that could be construed as abusive without the need for the stringent level of proof needed in criminal prosecution. Still, little evidence shows that children *initiate* these false allegations.

As part of this phenomenon, Gardner (1987) has coined the term parental alienation syndrome, in which one parent alienates the child against the other by focusing on harmful or negative characteristics to the extent that the child may even fear for his or her safety. The fear is then reinforced whenever visitation occurs (frequently irregular and in artificial situations). Counselors have become increasingly drawn into these adversarial situations, trying to substantiate the veracity of one side or the other—a very tricky role for those who were trained to believe children never lie. We now must learn to recognize stories that are “too good” or are rehearsed, inconsistencies with physical evidence, and inappropriately adult language as possible clues; and we must disregard other typical factors like fear of the alleged offender.

RITUAL ABUSE:

Probably no other aspect of sexual abuse has received more attention on television talk shows than ritualized abuse. Although we typically equate ritual abuse with satanic cult activity, the concept encompasses any variety of formal, structured, or ceremonial contact, even that occurring within a family (Brown, 1991).

In good part because of ritual abuse, counselors have had to learn about multiple personality disorders (MPD). Clearly, this form of abuse has produced the largest number of survivors with serious pathology, particularly within the category of the dissociative disorders, such as MPD. In fact, the number of traumatically affected

survivors with the most bizarre stories—including torture, sacrifice, and intricate complicity—ironically *creates* significant problems with credibility and validity. The accusations may or may not be substantiated by hard, physical evidence. Although some therapists support the extent of the problem because of the consistency of the stories told (Brown, 1991), others see those stories as *too* consistent to be realistic.

Again, counselors run the risk of being drawn into controversy. What does seem clear is that ritual abuse, with or without the sensational components, is a serious problem with potentially severe consequences. These consequences, primarily MPD, have presented a new challenge. More than other survivors, those with MPD test the limits of our traditional treatment strategies and typically require extensive and intensive treatment, with both individual and group therapies often provided by specialists.

SEX ADDICTION:

If ritual abuse has conquered the TV talk shows, sex addiction ranks as a close second. Even though most discussion of sex addiction or compulsive sexual behavior focuses on adult behavior (Carnes, 1983), sexual abuse issues overlap in two areas. First, of course, some children become targets for compulsive acting-out. Second, some advocates for the sex addiction model of treatment see this as the preferred treatment strategy for any offender, whether or not the concept of addiction has been proved.

Some hold that sexual abuse is, almost by definition, a compulsive behavior. However, experience has shown us that many incidents of abuse are much closer to impulsive behavior, albeit with established behavior patterns that make it look less than spontaneous. As will be discussed later in this lesson, sexual compulsivity can be one of the dynamics present, but it does not seem to be preponderant.

The System

Sexual abuse presents another major challenge to the counseling profession—the system. More than in any other counseling problem area, we are required to collaborate/coordinate/communicate with a child protective agency, law enforcement, juvenile/family courts, adult/criminal courts, probation, and, perhaps lots of lawyers. We are simply not trained to deal with these system elements.

We also experience the shortfalls of the system firsthand. Typically underfunded and understaffed, investigative agencies are sometimes slower to respond than we wish, often mired in bureaucracy and procedural restrictions. Invariably, they are in a classic no-win position—criticized, for example, for not taking action and for taking action that disrupts families, for having inadequate supervision and too many supervisor regulations. These shortfalls have resulted in discouragement for many of us, including an increasing reluctance to report marginal cases. Despite this discouragement, in all 50 states, we are still, of course, required to report abuse. Not only do we place ourselves in jeopardy by not meeting that mandate, but we generally place the child at greater risk. At least at this point, it seems that the risk of not reporting is greater than that of trusting the system.

In addition to their difficulties with protective agencies, counselors increasingly find themselves in adversarial civil and criminal proceedings, generally as expert witnesses. Because most mental health counselors will probably find themselves in this position, even if they do not consider themselves to be sexual abuse experts, it is essential to gain knowledge in the field and to also gather information and practice in expert testimony and forensic counseling.

MANAGED HEALTH CARE:

The restrictions placed on mental health professionals by managed health care have a significant impact on dealing with sexual abuse, a problem that defies the

notion of brief therapy. As in other areas of mental health treatment (e.g., chronic illness, personality disorders), it may be necessary to rely on other community agencies that are specifically funded to handle the problem. Those of us affected by managed care might have to restrict ourselves to a crisis intervention/stabilization role.

COUNSELOR TRAINING AND EXPERIENCE:

In order for counselors to deal effectively with sexual abuse issues, they must receive broad-based training in two areas. First, they must be **excellent counselors with multi-modal experience**—individual, group, family, child/play, affective, cognitive, sexual, behavioral therapies, and various expressive modalities (art, music, writing, and drama therapies). Second, **counselors must be experienced in the various aspects of abuse: evaluation and treatment** of both the victim and offender, **family treatment** (including the nonoffending spouse and siblings), and **treatment of the adult survivor**. Many, if not most, counselors have become isolated specialists, particularly in the area of victim and survivor treatment, whereas **few counselor/advocates have experienced contact with offenders**, thus leaving a void in their understanding of dynamics, patterns of abuse, and prognosis.

Intervention Strategies

Although the following discussion addresses intervention strategies for child victims, it is important to preface that discussion with the caveat that **sexual abuse treatment is most effective when done in an integrative approach, with as many family members as possible participating in the process**. This is true whether or not the family is moving in the direction of reunification. The following strategies can fit in an integrative approach or may be adapted.

Table 1
PEDOSEXUAL TAXONOMY

Age of participants

Child-Child*
Child-Adolescent[†]
Child-Adult
Adolescent-Adolescent
Adolescent-Adult

Setting

Intrafamilial*
Extrafamilial
• Offender is known to child
• Offender is a stranger

Dynamics of offender

Regressed (see Groth & Birnbaum [1978] for discussion of regressed vs. fixated offender)
Pedophilia (defined by DSM-III-R)
Rape (violent attempted or actual penetration)
Symptomatic (abuse is symptom of other major disorder; e.g., schizophrenia or developmental delay)
Addicted/compulsive
Ritualized abuse

* Child=prepuberty

[†] Adolescent=puberty-age 18

* Family=living unit

Source: Rencken, R. (1989). *Intervention strategies for sexual abuse*. Alexandria, VA: American Association for Counseling and Development.

TAXONOMY:

Partly as a result of the rapid growth in the area of intervention, relatively few attempts have been made to create a taxonomy that can assist the treatment process (Groth & Birnbaum, 1978; Giaretto, 1982; Finkelhor, 1984). Table 1 shows a pedosexual taxonomy (Rencken, 1989) that uses the dimensions of age, setting, and offender dynamics to describe a variety of child sexual interactions.

The primary benefit provided by a taxonomy is an understanding of the heterogeneity and complexity of the problem and the variable effects on the victim. The resulting system can then help in treatment planning and the prognostic process.

In the pedosexual taxonomy, we identify the category that best fits our case of concern in each of the

three categories. For example, the most common type is the Child-Adult-Intrafamilial-Regressed Offender combination. We know, for example, that this category usually has a good prognosis, and is often treated with family therapy. The prognosis is much less optimistic for Adolescent-Adult-Extrafamilial (known)-Rape cases, and the treatment approach is much different.

We can also use the taxonomy to make generally predictive statements about victims. For example, the greater the age gap (Child-Adult vs. Child-Child), the more a significant power difference and harmful effect on the child will be evident. Also, the closer the relationship between the child and offender (Intrafamilial vs.

Table 2 PRIMARY VICTIM REACTION AGE BY OFFENDER DYNAMICS			
<i>Dynamic</i>	<i>Age</i>		
	<u>Child-Adult</u>	<u>Child-Adolescent</u>	<u>Adolescent-Adult</u>
Regressed	Powerlessness	Confusion	Ambivalence
Rape	General trauma Fear/dissociation	Fear	Anger/fear
Pedophile	Ambivalence/guilt	Confusion/guilt	Guilt/rage
Addict/compulsive	Fear	Confusion	Guilt/rage
Symptomatic	Fear	Confusion/fear	Fear/anger
Ritual	Fear/dissociation	Fear/dissociation	Rage/dissociation

Stranger), the more likely the child will experience significant ambivalence or emotional conflict (love-hate). We also know that victims of pedophiles are likely to be more confused and rape victims more traumatized (Table 2).

REPORTING AND REFERRALS:

More, if not all, counselors will have to cope with sexual abuse issues even if they are not specialists in the field. We are all mandated to report abuse, with slight variations in reporting requirements from state to state. Despite the requirement, issues regarding those regulations arise consistently. Many counselors do not see reporting as being in the child's best interests in all cases and have apparently good reason for that concern. My general advice remains: When in doubt,

report. The protection of the child overrides all other treatment issues (Rencken, 1989).

Certainly, the mental health counselor will want to refer some sexual abuse cases, either by referring the primary client or suggesting a counselor or another mental health professional for the offender, siblings, nonoffending spouse, family, etc. As in any referral situation, we should seek providers who are both excellent general counselors and experienced in more than one perspective. At this time, no credentialing process has been established for the specialists in the field.

EVALUATIONS:

Because most of the victims that we see are prepubertal (Finkelhor, 1984), most victim evaluations are activity-centered; that is, centered around play with toys, objects, clay, drawing, or other expressive modalities. This is not to eliminate the use of appropriate standardized instruments such as self-esteem, behavioral, or depression inventories (Powell & Wagner, 1991). We have known about the advantages of play therapy for years in the general population, and those skills are essentially the same in dealing with victims (Conerly, 1986). In fact, one of the problems that beginning counselors may discover is the tendency to become interrogators, focusing on facts rather than the child. This, of course, flies in the face of play therapy techniques that allow children to express feelings in a way that makes sense for them more than for us.

The primary rule for evaluations, like therapy, is to focus on the child's feelings about what has happened rather than explicit details. This rule helps us to sort out three controversial areas in evaluations: discrepancies, leading questions, and the use of anatomically correct dolls.

Discrepancies. Newcomers to the arena of sexual abuse assessment and treatment are sometimes surprised at discrepancies between the stories told by children and by

admitting offenders. These discrepancies go beyond offender minimization or denial to basic differences of time, events, sequence, or even types of sexual behavior. Such disparities are also present even when comparing one child's stories over time—a nightmare for prosecuting attorneys but a very typical occurrence. Children, particularly young children, do not possess some of the logical and sequencing abilities to accurately encode some of the facts, but they can encode the feelings. In the long run, an evaluation style that focuses on the feelings will uncover equally accurate facts as a more interrogating style.

Leading questions. One frequent criticism of therapists, particularly those who testify as expert witnesses, is the use of "leading questions." Obvious questions such as, "What did your father do?" or, "Did he touch your private parts?" may be construed as leading questions and not admissible as evidence. More importantly, they may confuse the child who would be much more comfortable dealing with his or her feelings, including expected feelings of ambivalence.

Anatomically correct dolls. The third current controversy in evaluations surrounds the use of anatomically correct or anatomically accurate dolls. These commercially available dolls may be standard plastic dolls or cloth Raggedy Ann style dolls. They are neither correct nor accurate in their depiction of genitals but are more explicit than the neutered versions typically available, particularly with the presence of a penis. Although these dolls presented an initial breakthrough for mental health specialists, they have come under more criticism as, again, functioning in the same way as leading questions. They set up the possibility/probability of a response that may or may not be accurate. One specific criticism, for example, is that *most* (nonvictimized) children would undress dolls and even engage in some sexual or pseudosexual behavior. If the dolls are used as facilitative rather than investigative tools in either evaluations or ongoing therapy, the feelings can again be the primary focus.

INDIVIDUAL COUNSELING:

Counselors in the 1990s will probably be faced with a wider range of therapy needs in the area of sexual abuse than in previous eras. They will encounter a wider age range of victims—from young children through adolescents through adult survivors. They will also be faced with a range of offending behaviors, from one incident of manual-genital contact to long-term coitus. There will also be a range of time since the abuse took place, from recent victimization to the passage of years (even when working with adolescents).

All these factors point to the need for mental health professionals to be flexible in their treatment approaches. Both verbal and activity-oriented therapies will be necessary. Gil (1991) has an excellent review of play therapy strategies specific to abused children. As when conducting evaluations, feelings need to be the primary focus of ongoing counseling (Oaklander, 1978). Interviews can focus on the feelings around the abuse, around current adjustment, around peer and adult relationships, and about themselves. With this focus in mind, it becomes possible to see the counseling process as revolving around empowerment.

Empowerment becomes a central goal for counseling with all of those involved in the abuse process—the child at any age, the sibling, the nonoffending spouse/parent, the adult survivor, and the offender (Rencken, 1989). Personal empowerment not only assists the healing process but acts as one of our strongest forces for prevention of future problems, sexually related or not. Empowerment simply addresses the issue of control over one's life; empowered persons sense that they, not others, have the ability to make decisions and choices in their own lives. With that kind of (age-appropriate) power in a person's life, even the trauma of sexual abuse can be "filed away." Counseling issues may include self-esteem, decision making, effective and practical communication, and emotional and physical self-care.

FAMILY TREATMENT:

Family therapy and therapeutic involvement have long been core components in sexual abuse treatment (Giaretto, 1982; Rencken, 1989). Initially, family work was most closely connected with the possibility of reunification; that is, bringing the family back together under therapeutic and/or judicial supervision. Many families that exhibited positive prognoses and relatively low risk levels have successfully reunified.

The modality of family therapy has proved effective in far more cases than those involving reunification. Not only has it become a good process for evaluating the possibilities of reunification, but it has become helpful for situations in which reunification is not an issue, including extrafamilial abuse, blended families, and post-divorce situations. The open support and encouragement of a family can be one of the most important sources of empowerment for an abuse victim.

The key factor in this form of family treatment is the gradual reestablishment of family bonds, moving from dyads to triads to whole family counseling. It is important to ensure that any steps along this line are helpful; in other words, if only dyad therapy is possible in a given family situation, that is still beneficial. Therefore, most child victims should have some form of family treatment as part of their therapeutic plan.

One of the most dramatic and beneficial aspects of family work is known as the "apology session" (Rencken, 1989). This session, or series of sessions, is a confrontation between the victim and offender. It may be hostile or loving and may occur at various times after the abuse. The goals of the sessions are: to clearly allocate the responsibility of the abuse (on the shoulders of the offender); to allow the opportunity for a clear apology; and to encourage/empower the victim to continue the treatment process.

Ideally, the apology session should occur at the earliest point possible after the report while allowing for adequate trauma recovery for the victim and

preparation for both the victim and offender. Preparation includes a strong certainty on the part of the offender's therapist that the offender accepts total responsibility. If the apology session does not occur within 3 or 4 months, then much of the benefit may not accrue. The session should include the victim, offender, nonoffending spouse, child's therapist, and offender's therapist; and it sets the tone for the remaining family sessions. This should be undertaken regardless of the possibility of reunification.

GROUP TREATMENT:

The most efficient and economical treatment modality is **group treatment**. It can be effectively structured as an activities (play, art, movement) group for younger victims (Gil, 1991) or a more traditional, verbal group for early and later adolescents (Rencken, 1989). Besides the efficiency factor, **the group provides vitally important validation for the victim**: They are not the only child to whom this has happened, and it is not his or her fault.

Prevention

Sexual abuse prevention efforts in the public schools have had less than dramatically positive results (Tharinger, Krivacska, Laye-McDonough, Jamison, Vincent, & Hedlund, 1988; Crewdson, 1988; Conte, Rosen, & Saperstein, 1986; Krazier, 1986; Berrick & Gilbert, 1991). The typical "just say no" or "good touch, bad touch" approach has simply not been effective and has even been seen as negative by some authors who feel that these approaches just add responsibility to the child without providing any power.

As I have traveled around the country conducting workshops for both school and mental health professionals, I have posited **three alternatives to the current prevention effort**. First, our children clearly need general empowerment, not only for

sexual abuse prevention. Curricula and counseling in elementary schools should focus on self-esteem, decision making, creating options, conflict resolution, and other techniques that have been shown to empower in appropriate ways. Strong children are certainly less likely to be attracted to harmful behavior, whether it be abuse, gangs, drugs, or violence.

The second option for prevention is comprehensive sexuality education (kindergarten through grade 12). We now even have guidelines for such a comprehensive approach (SIECUS, 1991). If children understand sexual functioning and relationships, and have a positive philosophy about sex, they are in a better position not only to resist victimization but to create age-appropriate behavior and relationships (Yates, 1978).

The third alternative I present is seldom discussed in the literature. Because sexual abuse is a crime of power and, generally, power of males over females, gender equity education becomes increasingly critical. If the two sexes are perceived as essentially equal, the power tactics of abuse will not be necessary.

The relatively new field of sexual abuse treatment is slowly maturing. Clinical and research evidence is just now beginning to accumulate and is being measured against the continuing impact of societal pressures and changes. It is the task of this lesson to update these issues and place them into an understandable context. Perhaps no other area of intervention presents more of a challenge to the mental health professional. We must rise to that challenge.

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Questions Based on This Lesson

17. Ritual sexual abuse of children has potentially serious consequences, especially the development of:
- A. Bipolar mood disorders
 - B. Criminal activities
 - C. Multiple personality disorder
 - D. Mental retardation
18. Which of the following statements is correct?
- A. Only mental health professionals who are Nationally Certified Counselors are obliged by law to report suspected cases of child abuse
 - B. The decrease in the reported incidence of child sexual abuse over the past 20 years is attributed exclusively to more accurate methods of reporting
 - C. When allegations of sexual abuse are proved to be false, it is shown that in the majority of instances these accusations have originated from the involved children
 - D. For counselors to deal effectively with sexual abuse issues, they must be trained both in broad counseling with multi-modal experience and also in the various aspects of abuse itself
19. Which of the following statements is correct?
- A. The larger the age gap of a sexual abuse situation (Child-Adult vs. Child-Child), the more significant power difference and harmful effect on the child will be evident
 - B. Taxonomy provides little or no understanding of the heterogeneity and complexity of the sexual abuse problem and the variable effects on victims
 - C. Sexual abuse treatment is most effective when therapy focuses exclusively on the child, while the other family members are excluded from the process
 - D. The Child-Adult-Intrafamilial-Regressed Offender combination has a poor prognosis and is usually not helped with family therapy
20. Which of the following statements is correct?
- A. Unlike most child evaluations, evaluations of child victims of sexual abuse involve verbal communication rather than play with toys, objects, drawing, and the like
 - B. Although young children are commonly unable to encode feelings, they are usually very capable of encoding facts
 - C. The use of anatomically correct dolls has ensured an almost infallible level of accurate responses
 - D. The central goal for counseling with all of those involved in the sexual abuse process should be empowerment

Directions in Mental Health Counseling

VOLUME 3 • LESSON 6

Current Practice and Procedures of Group Psychotherapy

Martin G. Allen, MD

Dr. Allen is in private practice and is Clinical Professor of Psychiatry,
Department of Psychiatry, Georgetown University School of Medicine, Washington, DC.

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EDITOR'S NOTE

Group psychotherapy has developed over the centuries—more specifically in the 20th century—as an interpersonal psychological therapeutic experience, and has been shown to be effective in many studies. Because it is effective for many but not all, clients should be selected for groups based on the composition of the group and the client's suitability for profiting from a group therapy experience. Therapist styles may differ, as they do in individual psychotherapy, but the feedback and interpretations of both the therapist and group members usually provides a growth-enhancing therapeutic experience. Group therapy may be combined with individual therapy for appropriate clients; and some clients may be taking psychopharmacologic medications while simultaneously participating in group therapy.

In recent years, time-limited groups have been developed for specific populations, such as college students, divorced persons, persons with post-traumatic disorders, or for specific administrative requirements such as those presented by HMOs. In addition, specific populations such as children, adolescents, the elderly, substance abusers, or same-sex groups may enhance the group experience of members who can focus on specific problems or experiences.

Historical Background

Group therapy is often thought of as a relatively modern phenomenon, one that has been popularized by such current modes of treatment as encounter sessions and 12-step programs. In fact, today's groups have their origins in ancient history.

ANCIENT GREECE:

Aristotle held as his basic premise that humans are social animals. The Greek dramatists used the interaction between individuals and groups to present the tragic drama. Often, this included the presence of a chorus, who observed and commented on the drama and personalities.

EIGHTEENTH AND NINETEENTH CENTURIES:

Mesmer, the famous hypnotist, held group hypnotic sessions in the early 1700s. The nineteenth-century French sociologist Gustave Le Bon, who studied the psychology of crowds, believed the conduct of a group to be markedly different from that of the individuals who compose it. Le Bon emphasized two points. First, the group is capable of a higher level of altruistic sacrifice, giving, and compassion than any one individual in the group. Second, a group is also capable of cruel, aggressive ferocity beyond the nature of any one member.

EARLY TWENTIETH CENTURY:

The early 1900s was a period of great interest in group therapy (Ettin, 1988; Allen, 1990b; Mullan & Rosenbaum, 1978). The American sociologist Charles Cooley studied the primary "face-to-face" group, which he believed was referable to the basic primary group, the family. Also at that time Joseph Pratt, a Boston internist, undertook what is generally considered today to be the first attempt at group psychotherapy. In 1905, after he organized tuberculosis patients into groups in a classroom-like setting, Pratt reported increasing self-confidence and self-esteem. Alfred Adler

first used group methods in Europe, and Moreno, the famous psychodramatist, worked with groups in the period between 1910 and 1914.

THE WORLD WAR I-WORLD WAR II PERIOD:

The interwar period saw further use of group therapy (Allen 1990b; Mullan & Rosenbaum, 1978; Ettin, 1989). Edward Lazell established lecture classes for patients at St. Elizabeth's Hospital in Washington, D.C., and several years later, L. Cody Marsh, a minister who later became a psychiatrist, also described his group methods of psychotherapy. In 1921, Freud (although not a practitioner of group therapy) published his seminal work on group psychology (Freud, 1955). Freud, expanding on the initial work of Le Bon, studied the qualities of leadership and the contribution of the individual's ego ideal to leadership. The binding force of the group, Freud believed, was very much related to the leader and the identification of group members with the leader. Freud also traced group behavior back to the family. In 1935, Wender reported group therapy with borderline patients using psychoanalytic concepts; Harry Stack Sullivan began his work with groups of inpatients at St. Elizabeth's Hospital; and Kurt Lewin undertook his investigations into group process, the impact of the leader upon the structure and function of a group, and the climate of the group in its relationship to productivity. Lewin stated that it is usually easier to change individuals in a group than to change any one of them separately. This generalization, derived from studies of group function, is a basic tenet of group psychotherapy.

POST-WORLD WAR II:

Some psychoanalysts, notably Trigant Burrow, Lewis Wender, and Alexander Wolf, became interested in "group psychoanalysis" and started working with individuals in a group setting. Techniques also evolved as work on group methods continued both in the United States and in England. In 1946, the National Education Associa-

tion assigned research observers to discussion groups for the purpose of reporting the interactions and behavioral sequences of each meeting. Soon participants found that the interactional observations were helping them understand their own behavior and the development of groups. One year later, the National Education Association organized workshops at Bethel, ME, to study group process and group behavior, the individual's role in the group, and how personal and professional skills might be acquired through group sessions. At the same time, W.R. Bion was developing theories of group dynamics and group therapy at the Tavistock Hospital in England. Bion's "Basic Assumption" groups—which he defined as those of pairing, dependency, and fight/flight—have helped group therapists understand group patterns that detract from the "work" (task) of group psychotherapy. This Tavistock model of group interaction focuses on leadership, the individual's relation to the leader, and to authority in general. The emphasis is on the group as a whole, rather than on individuals in the group (Rioch, 1970).

THE PAST 25 YEARS:

During the 1960s, as encounter, sensitivity, and marathon groups were developing and being popularized, many clients were working in more standard forms of group therapy, where they dealt with conflicts, interpersonal relations, and transference distortions. Group therapy is now used with those who are taking medications as well as those who are not, and it may be combined with individual therapy under certain conditions. Group therapy is also widely useful for both inpatients and outpatients.

As with other therapeutic approaches in counseling, an eclectic approach has evolved over the years. Group therapy is used increasingly for specific populations (children, adolescents, and the elderly) and for clients with specific problems (eating disorders, substance abuse disorders, or victims of violence). Also, as briefer therapies become more important in meeting reimbursement guidelines of payers such

as health maintenance organizations (HMOs), the use of time-limited group therapy is increasing (Allen, 1970a).

The Efficacy of Group Psychotherapy

Group psychotherapy works. Many outcome studies have demonstrated both short-term and long-term changes in clients (Bloch & Crouch, 1985; Yalom, 1985; Corsini & Rosenberg, 1955; Mann, 1966; Pattison, 1967; Yalom et al., 1967; Kelman, 1963; Opalic, 1989), and those of us who regularly work with group therapy see its benefits for clients with both acute and long-term problems.

Kelman (1963) outlined how group therapy affects the induction of therapeutic change with clients through the processes of compliance, identification, and/or internalization. Analyzing the roles of therapist, client, and group in the induction of therapeutic change, he discussed the concept of corrective emotional experience and its relevance to therapeutic change, both in individual and group therapy. Of course, the basic importance of commitment, motivation to continue in therapy, and engagement in the therapeutic work is essential for meaningful change to occur.

Yalom (1985) identified several factors necessary to effect therapeutic change in group therapy. They include installation of hope, universality, imparting of information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors. Of these, Yalom found group cohesiveness to be the most important factor in bringing about therapeutic change. As with all forms of therapy, some combination of intellectual and experiential insight should occur and lead to both internal and external growth, development, and symptom relief.

Administration and Procedure

Much has been written about factors such as the length of group therapy, the location, the membership composition, and the periods of preparation. Authors have advocated a wide range of procedures. I will summarize my procedure and administration, recognizing that conducting group therapy has no one "right" method. Many experienced and thoughtful group therapists practice in a variety of ways.

In group therapy—as with all forms of therapy—a basic trust and therapeutic alliance in the context of ongoing therapeutic work is essential. It involves the development and maintenance of a safe "holding" environment in which participants can be free to express thoughts, feelings, and fantasies. The group therapist must function not only to facilitate interaction among the group members but also to foster a sense of basic trust in an atmosphere of therapeutic work. As such, the group therapist may sometimes function as a referee, transference object, facilitator of interpersonal interaction, and interpreter of verbal or nonverbal behavior; at other times, he or she serves as a supportive, understanding listener. The group therapist usually is responsible for deciding who may enter the group and for dealing with issues of termination and with members who are disruptive to the group.

I prepare clients for group therapy in a variety of ways. I ask them if they have previously participated in any experiential or therapy groups and what that experience was like. I also inquire as to their experience in other groups such as vocational, educational, friendship, and social groups. I pay particular attention to behavior in groups compared with behavior in dyadic or intimate situations. Many clients find that their emotions, feelings of competitiveness, and reactions to authority intensify in group situations. Other clients comment that they feel comfortable in one-on-one situations but are often anxious, uncomfortable, silent, or overwhelmed in group situations. If a client reveals that he or she feels uncomfortable with the opposite sex, I often mention that mixed group therapy affords the opportunity

to understand how and why relating differs between the sexes and to see what areas of human experience are shared and what areas have differences. By mentioning group therapy in the initial consultation, the client starts thinking about that treatment method.

I specifically select clients for group (or combined) therapy when I hear of problems in relating to other people, in feeling socially isolated, in verbalizing emotions and feelings (especially to others), in assertiveness and self-esteem, and of feeling different, inferior, or intimidated by others. Clients who have a poor observing ego are also appropriate. They all can gain from hearing others' revelations about themselves or expressing feelings to which they can relate. These clients also may have valuable observations and insights toward others; when they contribute to the group, it can be pointed out that their observation was helpful, perceptive, and might apply to themselves as well, seeing in others what we are unable to see in ourselves and expressing for others what we are unable to express for ourselves.

When clients are resistant or anxious about revealing themselves in a group, I say, "I'll be there with you," or "I realize this might be difficult for you, but I think ultimately it will be helpful." By mentioning group therapy early in the therapeutic process, it is not so surprising when the subject is raised suddenly later during therapy. Group therapy can be mentioned several times, so the client can get used to the idea without feeling rejected or forced into a group. Perhaps the most important factor in dealing with resistance or anxiety about group therapy is the attitude of the therapist recommending it. If the therapist is comfortable and believes in group therapy in general and for the client in particular (and is not recommending group therapy out of convenience or anger at the client), that attitude will be conveyed to the client. Also, if group therapy is presented as a natural evolution of development and progress in therapy itself, the client can perceive group therapy as a sign of advancement and progress.

I do not have a fixed period of time for preparing clients. Some are referred for group therapy, whereas others refer themselves, having had a beneficial experience in the past. The latter are often able to join a group after one or two initial evaluation sessions. Other clients may enter treatment in a crisis situation, such as divorce, and they may not be ready or able to join a group for some time. In such cases, I often mention the possibility of group therapy "in the future" if it seems possible and appropriate. Some therapists have spoken about the importance of a lengthy evaluation and developing a treatment relationship prior to entering group therapy to ensure a strong client-therapist alliance, whereas others have advocated the group itself as the focus of treatment. These opposing views are based on whether membership in the group stems from a relationship to the group therapist or an emotional attachment to the group as a whole.

When discussing group therapy with prospective clients, I emphasize the importance of being present and expressing thoughts and feelings as openly as possible. I ask each prospective member to make a commitment to the group for at least 5 months, to underline the seriousness of the commitment, to give the client a chance to meet the group members and get involved in the group, and to minimize the potential disruptiveness of a "revolving door" situation in which membership changes frequently.

My group therapy sessions last one and one-half hours; most groups are between one and two hours duration. I bill clients at the end of the month and ask to be paid before the 15th of the following month. I charge for all sessions in which the group meets, even if a client is absent from the group, because I am providing ("selling") a total ongoing therapeutic process. Also, every participant is expected to attend the group and has a membership "place" in the group. If a client is late or absent for any reason, that behavior needs to be questioned (preferably in the group) as an expression of resistance or acting out. In addition, I announce my vacations well in advance, in case clients would like to plan their vacations for the same time.

Once a year I conduct an extended session with the group to increase openness, intimacy, and cohesiveness and to decrease rigid defenses (Allen, 1990c). The extended session, in the context of ongoing group psychotherapy, often results in breakthroughs and insights that may not have been achieved otherwise or may have taken much longer to achieve. Some therapists schedule several extended sessions in a year.

Absences, side effects of medications, fees, and the like are discussed in the group setting, if possible. In fact, everything should be brought into group therapy. In keeping with that philosophy, I do not forbid discussions or contact between group members outside of group sessions, because such a restriction is unnatural, cannot be enforced, and deprives the therapy of potentially useful material. The basic recommendation remains: All thoughts, feelings, fantasies, and behaviors should be discussed in the therapy group, including any instances of contact outside the group meetings.

Even though some group therapists insist on charging the same fee to all clients, I recognize that there may be special circumstances (e.g., a client has lost a job, is a student without income, or has been terminated by his or her insurance company), so clients may be billed at different rates. Such differences may promote feelings of jealousy or rivalry, with a variety of accompanying fantasies, and these can and should be discussed and explored in the group setting.

Selecting Clients for a Group

Criteria for group therapy are based on an ability to relate to others (Grunebaum & Kates, 1977). That specifically implies an ability to relate to and react to others and a reasonable degree of appropriate affect and interpersonal awareness.

Some groups, such as adolescents, the elderly, and alcoholics, are best treated in homogeneous groups. Adults are probably best treated in groups that are heterogeneous in age, sex, personal background, and psychopathology.

Conditions for which group therapy is particularly appropriate include charac-

ter disorders, problems of sexual or social relatedness, forms of hysterical personality (especially conflicts "acted out" in the group setting), and depression, if the person is verbal.

Clients who generally are less suitable or not suitable for group therapy include those who are unable to relate to others because of a strong affectual block, as with catatonia; the grossly agitated or psychotic who are hallucinating or delusional; retarded people who are depressed, nonverbal, and manifest psychomotor retardation; clients actively abusing alcohol or hallucinogenic drugs, which impairs their ability to attend regularly and relate to others; persons with organic mental disease who are disoriented; and persons of inadequate intelligence. In addition, sociopathic clients are usually poor risks for interactional group therapy: Often they are destructive in the group and unable to receive and process feedback from other clients.

CASE STUDY I:

A woman in her twenties was referred for group psychotherapy by her individual therapist after forming a highly sexualized, delusional transference. The client felt that her therapist was seducing her each time he blinked his eyes, crossed his legs, or shifted position in his chair. She had frequent romantic and sexual fantasies. She bought a dog, named it after her therapist, and slept with it each night. Although the therapist attempted to bring reality into the situation and reduce the transference, it was not diminished in its intensity or erotic quality. A referral to group therapy was made in the hope of diluting the transference. The client did enter group therapy, but the delusional, erotic transference persisted. Therefore, individual therapy was terminated, and the client was able to work in group therapy while not developing the intense, sexualized transference toward the group therapist or any group member.

CASE STUDY II:

A man was continually provocative, angry, and insulting to cover internal depression and pain. He had recurrent depression with strong borderline personality features manifested by paranoid thoughts, lability, and great anger. He avoided intimacy and pain by provoking and insulting everyone, both at work and in personal relationships. He had managed to alienate and reject all those around him. As a result, the therapist had great ambivalence about his joining the group and wondered whether he would be destructive to the therapeutic process. When he joined the group, he was unable to insult and alienate "all the people all of the time." Consequently, one or two people in the group consistently were able to empathize with him, feel his underlying pain, and tell him that they understood how he was feeling. Gradually, he was able to trust both the therapist and the group, listen to others more attentively, and realize the effect he was having on others.

Combining Group and Individual Therapy

Group and individual psychotherapy can be combined in a variety of ways (Bloch & Crouch, 1985; Yalom, 1985; Ormont, 1981; Rutan & Alson, 1982). One option, individual therapy with one therapist and group therapy with another, demands communication (and trust) between the individual and therapist. Such treatment is especially useful for clients who have massive separation anxiety and for whom therapeutic contact with at least one therapist is supportively essential. Although such therapy can promote splitting, such a defensive "primitive" mechanism may be observed, pointed out, and understood in the living situation. It can be very useful for a client to express anger at one therapist, who may represent a parent, and receive support, love, and comfort from the other. Combined therapy also gives clients the opportunity to work through highly individual issues first

and then bring them into the group. Some clients begin with individual therapy and are able to gradually add (or substitute) group therapy for individual sessions as they move from the dyadic relationship of individual therapy to the more complex matrix of interpersonal relationships symbolic of entering the world beyond the mother-child dyad. With combined therapy, clients often learn from one another in a group, identify with others' issues, and grow and learn as they see others doing the same. They can then bring issues from the group into individual sessions, and conversely, bring issues from individual sessions into group therapy, where they can receive varied feedback.

In addition, clients who are in a "crisis," as occurs following divorce, job loss, or trauma, often need additional time in therapy. They are more likely to benefit from a group that meets only once a week, rather than one that meets two or three times a week. In any case, a client may have more conflicted, secretive, "shame-filled" issues that they feel more able to work on individually, rather than expressing them in a group. Still, some clients have more intense transference conflicts in the individual therapy situation and may feel more able to broach highly charged, conflicted issues in the group setting, where they feel support from other group members.

Sometimes when combined therapy is used with some but not all clients in a group, feelings of jealousy and rivalry may ensue. Such emotions, which are based on the reality of the differences, can often be used in fruitful exploration of differences in original family relationships. Whether a client feels favored or rejected, understood or not understood, are affectually charged issues that should be explored and worked through in combined therapy. In addition, "difficult" clients who are often highly resistive and are silent or angry can often profit from combined therapy. They may have reached an impasse in individual therapy, so the therapist can receive "help" in understanding, observing, and working with them in the group. In particular, clients

who are not psychologically minded and have little observing ego are often able to profit from combined therapy. Even though they may be perceived as boring or frustrating in individual therapy, with the living experience of group therapy and the observations and feedback from group members, they may develop more of an observing ego as they learn from both the therapist and other participants to observe, understand, and work through personal conflicts.

Another issue that comes up in combined therapy is confidentiality and the importance of having every subject open to discussion in both individual and group therapy. With clients in combined therapy, it is essential that they understand that every issue needs to be addressed in both therapies. When the group and individual therapists are not the same person, clients need to understand that regular and open communication between both therapists will take place. Sometimes clients will be reluctant to bring up information individually if they know it will be discussed in the group, and they may ask me not to reveal such information to the group. Although I will not agree to their request specifically, I do say I will wait for the time when they are able to bring it up in group and I will "look forward" to that time. Therefore, while not agreeing to withhold personal or guilt-laden information from the group for an indefinite time, I will support, encourage, and emphasize the importance and necessity of all issues being brought into the group on the client's initiative. In fact, no conflicts, behaviors, fantasies, or experiences should be withheld from the group, if openness, mutual trust, and group cohesiveness are to be maintained and expanded.

In addition, clients are often very different in individual and group therapy, and both the therapist and client may be quite surprised by that difference, which needs to be acknowledged, observed, understood, and worked through. Eventually it may be traced to the contrast between how a person feels in the one-to-one dyadic mother-child relationship versus the larger family group, or how one behaves in the small

intimate family when compared with actions in the external world. As the therapeutic process continues, some integration between such discrepancies may take place. Combined therapy enables the therapist to experience and observe a client interacting with others—not just hear reports about such interactions.

In combined therapy, an individual therapist may have a blind spot and not be observing or aware of certain verbal or nonverbal behaviors. In the group setting, with the observation and feedback of many members, such difficulties or countertransference blocks are much less likely. Also, resistances and denials that might be avoided or rationalized in individual therapy may often be more openly confronted and realized in the group setting. Then they can be brought back into the individual sessions for further therapeutic work.

Combined individual and group therapy with a different therapist in each setting is sometimes helpful. For example, if a client has developed a psychotic transference, group therapy with a different therapist may help resolve that situation. For a fragile, borderline client or a dependent client with a great deal of separation anxiety, having a separate group therapist (who takes vacations at a different time) is helpful in maintaining continuity of care. Conversely, if a client has become too dependent or too symbiotically fused with a therapist, adding group therapy (especially with a different therapist) may help to separate gradually from the first therapist. Also, if a therapist has significant unresolvable countertransference issues or is feeling especially hostile toward, frustrated with, or sexually attracted to a client, adding group therapy (especially with a different group therapist) can help the overall therapeutic work. Even after consultation or supervision, a sense of bewilderment, confusion, or lack of understanding or empathy with a client (thereby affecting the overall therapeutic alliance) may be dealt with by adding group therapy with another therapist.

Group and individual therapy with the same therapist is especially appropri-

ate for clients who are very anxious in groups but who have gradually developed a sense of trust and alliance with their therapist. For such clients, entering group therapy with the trusted therapist gives some sense of reassurance. Also, with some borderline clients, splitting may be so disruptive that the same therapist might be indicated for both group and individual therapy. However, the client may split among the group members, thereby presenting the group with the pathologic activity. Individual therapy sessions in addition to group therapy may also be appropriate for clients with special crises in their lives such as job loss or divorce or exacerbations in their emotional states, such as emerging suicidal thoughts in the setting of depression.

Psychoanalytic Group Psychotherapy

Years ago, psychoanalysts who started practicing group psychotherapy would often focus on one client for a prolonged period of time, with the analyst or group making interpretations. Such "psychoanalysis in groups" is less common today (Wolf & Schwartz, 1962; Locke, 1961; Wong, 1983). Currently, a psychoanalytic approach to group therapy is one in which attention is paid to fantasies, dreams, internal conflicts, and other aspects of conscious and unconscious mental activity (Wong, 1983; Ezriel, 1980; Ezriel, 1952). Psychoanalytic group therapy assumes that a structural change will take place over time, with the resolution of infantile conflicts and the working through of highly cathected issues. It is a less supportive, more intensive working-through, growth, therapeutic process.

In psychoanalytic group therapy, the clients are most often verbal, are more "healthy," and have good access to their experiencing and observing egos. Such clients bring into the group—for all to observe and experience—the internal objects, representations, fantasies, drive, and drive derivatives in an ever-changing mosaic. A complex interactional matrix of multiple transferences and projections of both real and fantasied objects from both childhood and later life develops. All are interwoven in a rich, multicolored, multidimensional tapestry.

In group therapy, multiple transferences and projections are more likely, and instead of being a problem or deficit to therapy and insight, they can be viewed as enriching, facilitating enhancements to the therapeutic process. Mechanisms such as splitting, projective identification, and denial are more likely to be recognized by the individual and by other group members (Wong, 1983).

The group therapist provides a relatively safe environment, both psychologically and physically containing, to facilitate interaction and expression, to provide a blank screen for transference development, and to recognize that more intense and more relevant transferences may develop toward other group members. In addition, observations and interpretations toward both individuals (about interpersonal interactions) and the group as a whole can be made either by the leader or by other group members. Such interpretations and observations are hopefully made when their timing and nature is therapeutically useful in achieving insight and mutative change. The overall goal is to be conscious of one's needs and desires (especially narcissistic and exhibitionistic needs that are more likely with the group as an audience) and to focus on the group "task" of therapy (Rioch, 1970). Psychoanalytic group therapy provides symptom relief, personal growth, psychological insight, mutative change, structural change, and awareness of unconscious conflicts and their childhood origins.

Other Group Therapy Approaches

Like individual therapy, other group therapy approaches can be classified as interpersonal, existential, supportive, cognitive, or confrontive (Mullan & Rosenbaum, 1978; Yalom, 1985; Kelman, 1963; Yalom, 1980; Whitaker, 1987; Rothke, 1986). In any case, the therapeutic goals may need to be modified from the more ambitious, extensive, long-term goals of psychoanalytic group therapy. Such goals may focus more on the beginnings of interpersonal sharing, mutual sup-

port, or symptom relief. In addition, some groups might focus on support for abstinence from alcohol, whereas others work on understanding and support for clients who have been sexually abused. In all cases, the degree to which a group can develop cohesiveness, trust, mutually shared values, and understanding determines how completely the therapeutic goals can be achieved. Group therapy may be extremely useful in a supportive or symptom-reducing manner without necessarily enhancing personal growth and structural change. But if there is great disparity, distrust, and separateness in a group—and as a result the different needs and goals are not met—it will lead to fragmentation and dissolution of the therapeutic experience.

Use of Medications with Group Psychotherapy Clients

As with all clients, medications may be specifically indicated for physiologic, cognitive, or affective signs and symptoms. When this occurs, the group therapist has a clear responsibility to refer the client to an expert in the field.

Salvendy and Joffe (1991) have presented a comprehensive discussion of this subject with excellent clinical examples. The use of pharmacology might be viewed by the client or by other group members in a positive or negative way. Also, as we know, side effects may complicate treatment with medications. In such cases, side effects need to be discussed beforehand and whenever they occur. In group therapy, it is important to raise these subjects in the group, not separate from the overall group process. Other clients in the group may have experienced side effects and may have been helped (or not helped) by medication. In any case, the use of medications can be a point of sharing between clients that is often beneficial. The client will feel less alone and less anxious in dealing with a medication and its side effects when fellow clients can compare and discuss their experiences with the same medication.

CASE STUDY III:

A very bright graduate student was depressed and borderline, with bulimia, self-destructive relationships with both men and women, and compulsive stealing. She had been hospitalized and received medication during the hospitalization, but she adamantly refused medication subsequently, even though she had periods of near-psychosis and suicidal thoughts. Over the course of several years, she connected well with her therapy group—expressed feelings about herself, a symbiotic relationship with her mother, and abandonment by her father—and established an increasing sense of trust and attachment to members of the group. However, she still refused medication during crises, even when recommended by her therapist. At one point in the group, the subject of medication was being discussed by other group members. She turned to me and said, "Tell me that I don't need medications, that they would not be helpful." I responded I could not say that, because I did not believe it. After hearing how medication had helped other clients in the group, she reluctantly agreed to a trial of antidepressants. Within two weeks, she reported feeling better. In the following weeks, she related how her whole life was changing, that she was increasingly optimistic, and that daily suicidal thoughts had disappeared. Clearly, her sense of trust in me and the group, seeing improvement in other group members when medications were added, and acknowledging unresolved painful memories, symptoms, and feelings all helped to change her mind about medication.

Regression in Group Therapy

The potential for regression in group therapy always needs to be evaluated in terms of its tendency to facilitate ego strength and therapeutic change or, conversely, ego fragmentation and clinical worsening. Such an evaluation needs to be performed both before and during any form of therapy, including group therapy.

Frequently we find that a client's potential for regression is different in group therapy than in individual therapy. In individual therapy, clients may fragment and regress when transference develops (transference "psychosis") in the closeness of the dyadic relationship. In such cases, clients feel especially anxious and find the intimacy too threatening or fragmenting. This may be attributed to a special erotic attachment or perhaps a history of significant physical, sexual, or emotional abuse. For such clients, the therapy group can provide a haven—a sanctuary in which they find more support, understanding, and reality validation.

Conversely, some clients are more likely to regress in group therapy when the group represents the unconscious, the primitive libidinal state, the primitive maternal object, or even the intrauterine existence. Other clients may regress and fragment because of the presence of one particular group member to whom they have an especially strong (often transference-based) reaction that they are unable to work through. For these clients, individual therapy often provides a haven where they feel nurtured, supported, and more intact.

In either case, combined therapy should be considered as a way of providing both a "haven" and an opportunity to deal with the intensity of the regressive experience. For some clients the intensity and fragmentation proves too great; consequently, a reformulation of the therapeutic plan must be instituted.

Obviously, an assessment of the regressive potential is related to evaluation of diagnosis and ego boundaries. In general, clients who have hysterical or borderline characteristics and who are more likely to be both emotional and active in the group process are also more likely to fragment and regress in that setting. Conversely, obsessional character types, who are usually more intellectualized and controlled, may benefit.

Summary

Clients should be selected for groups based on the composition of the group and the client's suitability for profiting from a group therapy experience. Therapist styles may differ, as they do in individual therapy, but providing an atmosphere in which a client may profit from the feedback and interpretations of both the therapist and group members is most often a growth-enhancing experience. Group therapy may be combined with individual therapy. Combined group and individual therapy may enhance the clinical improvement and therapeutic experience for the client. In recent years, time-limited groups have been developed for specific populations (college students, divorced persons, clients with post-traumatic disorders) or for specific administrative requirements such as those presented by HMOs. In addition, specific populations such as children, adolescents, the elderly, substance abusers, and same-sex groups may enhance the group experiences of members who can focus on specific problems or experiences.

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Questions Based on This Lesson

21. In 1963, Kelman, outlining how group therapy works, stressed that:
- A. The conduct of a group is markedly different than that of individuals
 - B. The binding force of the group is very much related to the leader and identification of group members with the leader
 - C. The processes of compliance, identification, internalization, and/or corrective emotional experience play important roles in the therapeutic effect
 - D. Hypnosis could be effectively conducted in group settings
22. Yalom found which of the following elements to be the "most important" factor in bringing about change in group therapy?
- A. Group cohesiveness
 - B. Catharsis
 - C. Imitative behavior
 - D. Activation of altruism
23. Which of the following statements about group therapy is *correct*?
- A. Members on psychoactive medications should not be in group therapy because the group members always endanger compliance
 - B. Some clients who are likely to regress detrimentally in individual therapy are less likely to do so in the group therapy context and vice versa
 - C. The primary tactic employed in psychoanalytic group psychotherapy today involves focusing on one client at a time for a prolonged period, with both therapist and other clients actively making interpretations
 - D. In the first case cited by the author, the young woman's intense, highly sexualized, delusional transference seen in individual therapy immediately vanished in the group therapy setting
24. Which of the following statements about combined individual and group therapy is *incorrect*?
- A. A client may be working through conflicted, secretive issues that he or she needs to work through individually before bringing them to the group setting
 - B. Group therapy can serve to surmount an impasse reached in individual therapy
 - C. Every issue the client works through needs to be explored in both therapies
 - D. None of the above

Directions in Mental Health Counseling

VOLUME 3 • LESSON 7

Psychotherapy with Dual Diagnosis Clients: Issues and Interventions

Emil Chiauzzi, PhD

Dr. Chiauzzi is Clinical Director of the Addictions
Treatment Program at the Waltham-Weston Hospital, Waltham, MA.

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Lawrence Gerstein, PhD
Barry Glick, PhD, NCC
Carl Malmquist, MD
Robert J. McAllister, PhD
Retta C. Trautman, CCMHC, LPC
William J. Weikel, PhD, CCMHC, NCC

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Editor's Note

As much as 80% of substance abuse populations concomitantly suffer from one or more mental disorders. Moreover, it is believed that 40% of clients presenting for treatment of alcoholism suffer with an affective disorder, and 30%–40% of those with affective disorders simultaneously abuse alcohol or other depressant drugs. Counseling with the dually diagnosed is especially complex because of the intricacy of any dual diagnosis. The counselor needs to take care in assessing *individual* differences in substance use patterns, mental status, and perceived reasons for using substances. To complicate matters further, coexisting psychological disorders and substance abuse often affect the course of each other; thus, traditional psychological and chemical dependence approaches may not satisfy treatment needs of the dually diagnosed.

In this lesson, Dr. Chiauzy discusses this extremely complex topic—characteristics of the dual diagnosis client and appropriate treatment approaches. The author outlines the relationships between psychopathologic and addictive disorders, treatment models, psychotherapy issues, stages of psychotherapy, and relapse prevention. It is important that counselors fully understand the dual diagnosis problem so that they can confront the unique counseling difficulties associated with dual diagnosis clients, assess the proper treatment stage, and appropriately implement the author's recommendations at any given time in the recovery process.

Therapy with dual diagnosis clients can be a frustrating process for both counselor and client; a setback in treating the substance addiction may precipitate a setback in treating the psychological disorder. Therefore, the counselor must be able to discuss objectively with the client the intricate nature of the dual diagnosis problem as well as specific treatment goals. Proper understanding of the dual diagnosis problem by both counselor and client can reduce the impact of minor setbacks, eliminate unrealistic goals, and foster a productive counselor-client team relationship in the recovery process.

The Dual Diagnosis Problem:

Introduction

As the sophistication of addictions treatment has grown, ignoring the treatment complications posed by those with both addictive and mental disorders has become impossible. Statistical estimates are quite dramatic, as there is a major overlap between mentally disordered and addicted populations. **The dually diagnosed comprise as much as 80% of substance abuse populations and 30%–50% of psychiatric populations** (Kosten & Kleber, 1988). Weiss and Rosenberg (1985) found that **40% of clients presenting for treatment of alcoholism were suffering from an affective disorder, and 30%–40% of those presenting with affective disorders were abusing alcohol or other depressant drugs.** Other studies indicate that 10%–30% of alcoholics have panic disorder, and about 20% of those with anxiety disorders abuse alcohol (Cox, Norton, Swinson, & Endler, 1990). When entering treatment, about **two thirds of alcoholics have symptoms that resemble those seen in anxiety disorders** (Ross, Glaser, & Germanson, 1988). Over the course of a lifetime, **between 10% and 65% of schizophrenics experience substance abuse disorders** (Mueser, Bellack, & Blanchard, 1992). The prevalence of schizophrenia is about four times greater in alcoholics than in nonalcoholics (Helzer & Pryzbeck, 1988). **Cocaine addicts have a high prevalence of concurrent depression, bipolar disorder, and attention deficit disorder** (Group for the Advancement of Psychiatry, 1991), and the **lifetime risk of major depression among opiate addicts may be as high as 75%** (Rounsaville, Weissman, Kleber, & Wilber, 1982).

One survey of persons admitted to an inpatient substance abuse program found that 57% had personality disorders (Nace, Davis, & Gaspari, 1991). Evidence from that study suggested **those clients used more illegal drugs, were less satisfied with their lives, and were more impulsive than were substance abusers without personality disorders.** Antisocial personality disorder is most frequently diagnosed: alcoholic men range up to

50% and alcoholic women range up to 20% (Blume, 1989). This is significantly greater than the 4% of males and 0.8% of females diagnosed as such in the general population (Helzer & Pryzbeck, 1988). The second most frequent personality disorder diagnosed was the borderline type, in about 10%–20% of cases (Mirin & Weiss, 1991). In general, the latter group tends to manifest poorer impulse control and reality testing, more depression, and greater antisocial behavior than those without borderline pathology.

The combination of mental and addictive disorders is associated with significant impairments and poorer treatment outcome. The best predictor of relapse in addiction is psychological severity; i.e., addicted clients with severe psychopathologic disorders have difficulty benefiting from inpatient and outpatient addiction treatments (McLellan, Luborsky, Woody, O'Brien, & Druley, 1983). Conversely, those with low psychological severity can benefit from virtually any type of addiction treatment.

What difficulties do dually diagnosed clients present in counseling? Cross-sectional studies have shown that they are more likely to be disruptive, aggressive, and verbally hostile, and experience difficulty managing the practical aspects of their lives (Drake, McLaughlin, Pepper, & Minkoff, 1991). Also, dual diagnosis clients lack the coping skills necessary to use treatment, are treatment noncompliant, are prone to residential instability, and are more likely to become institutionalized in hospitals and jails.

Relationships Between Psychopathologic and Addictive Disorders

Meyer (1986) suggests several ways in which psychopathology and addiction may coexist: (1) Psychological disorders may be risk factors for the development of addiction; (2) psychopathology may alter the course of addiction; (3) substance use

may alter the course of psychological problems; (4) psychopathology may develop as a result of addiction and persist after the substance abuse is arrested; and (5) psychopathology and addiction may originate from a common vulnerability. Clients with these combinations may present in similar ways, but for very different reasons. **Interpreting the mental disorder as more critical than the addiction (or vice-versa) may be misleading and produce poor outcomes.** Instead, the counselor carefully needs to assess *individual* differences in substance use patterns, mental status, and perceived reasons for using substances.

The relationships between psychopathology and addiction become even more complex when psychological disorders are considered individually, because the linkages may vary among disorders. Research indicates **a prevalence of coexisting affective disorders and substance abuse, and that these disorders affect the course of each other.** Furthermore, affective disorders increase the risk of substance abuse, and these disorders share common vulnerabilities (Bukstein, Brent, & Kaminer, 1989). Depression may reduce treatment compliance, and alcohol use may reduce the efficacy of depression treatment. Alcoholics with depression generally began drinking at an earlier age and progress to problem drinking sooner than alcoholics without additional psychopathology. Familial affective disorders may also serve as risk factors for substance abuse.

Bukstein and colleagues (1989) also suggest varying relationships between anxiety and substance abuse. They found **high rates of agoraphobia, phobias, and panic disorders among substance abusers, with the overlap resulting from:** (1) **Withdrawal symptoms** of alcohol, opiates, or barbiturates; (2) the need for **tension reduction**; or (3) an **increased risk of anxiety disorders in relatives of alcoholics.** In addition, a minority of the dually diagnosed (less than 25%) develop an anxiety disorder *after* a period of substance abuse (Mirin & Weiss, 1991).

Finally, **schizophrenics are thought to use substances to reduce such symptoms as poverty of speech, affective flattening, anhedonia, asociality, attentional impairment, or dysphoria** (Schneier & Siris, 1987). In reality, **substance use (particularly the use of alcohol) by schizophrenics can compromise already-impaired cognitive functions such as memory**. It can also affect the course of schizophrenia, because stimulant use can precipitate an earlier onset of schizophrenia in high-risk persons; alcohol use has been associated with higher vulnerability to relapses among schizophrenics (Mueser, Bellack, & Blanchard, 1992). Also, relapses are often caused by discontinuation of psychotropics.

Organizational Impediments to Effective Treatment

Because of the often-confusing clinical picture presented by the dually diagnosed, **traditional psychological and chemical dependence approaches and assumptions may not meet treatment needs**. In fact, many impediments within both the mental health and chemical dependence systems may actually preclude effective treatment (Wallen & Weiner, 1989). Within the mental health system, substance dependence has been considered secondary to the psychopathologic disorder. However, as stated earlier, there may be *several* relationships between substance use and psychopathologic symptoms.

Other assumptions surrounding mental health treatment of the dually diagnosed may also impede clinical progress. **Identification of underlying conflicts is a common goal of psychodynamic psychotherapy, but intervening in this manner during early phases of recovery may be counterproductive and actually increase the probability of relapse** (Kaufman, 1989). That is especially true of exploration of past trauma, such as physical or sexual abuse. In addition, there has been a **long-standing strain between the mental health professions and 12-step groups**, because professionals may regard such groups as scientifically untested or religiously biased. However, in recent years there has been a

thaw, which may be attributed in part to the fact that many Alcoholics Anonymous (AA) members are also being treated for psychological disorders and recognize the benefits of combining self-help with psychoactive medication and/or psychotherapy.

Impediments also exist within the chemical dependence system. Many recovery counselors base their treatment on their own recoveries; i.e., self-help involvement, and may not receive training in psychopathologic diagnosis. Within self-help groups, there has been a **bias against the use of psychoactive medications** because they are thought to represent substitutes for drugs of choice. In addition, many of those in recovery feel that "you have to have been there." Such thinking results in a minimization of potential benefits from professional treatment. Finally, as in the general population, there is much **fear and ignorance of mental disorders.** Many people equate a diagnosis of mental disorder with being "crazy." Again, with increasing recognition of dual diagnosis, greater training and understanding have been devoted to the diversity of those who are addicted.

Treatment Models

Researchers have recognized the deficits mentioned above and have begun to address the need for comprehensive models of treatment. Several that balance psychological and addiction awareness will be discussed: (1) **Integrated treatment approaches;** (2) **the self-medication model;** and (3) **the biopsychosocial model.** Each model offers a different conceptual framework for combining addiction and psychological treatment, but all recognize **abstinence as a prerequisite for a positive outcome.**

INTEGRATED TREATMENT:

The integrated treatment model seeks to identify commonalities between traditional recovery and psychological interventions, relying on a disease-oriented approach (Evans & Sullivan, 1990; Johnson, 1992; Minkoff, 1991). These commonalities

can include heritability, etiology, chronicity, incurability, potential for relapse, and denial (Minkoff, 1991). **The approach de-emphasizes traditional techniques such as confrontation and seeks to "engage" the client in a long-term recovery outlook. Each disorder is considered primary, regardless of onset and severity.** A comprehensive use of this model would include components such as **crisis management, medication management, psychosocial rehabilitation, relapse prevention, family support and education, case management, and 12-step programming.** This model is useful in combining current treatment approaches in a pragmatic and comprehensive manner, but relies on traditional biological assumptions about the addictive process.

SELF-MEDICATION:

The self-medication model is based upon the psychodynamic notion that certain substances are chosen preferentially for their ability to ameliorate specific negative affects such as rage, loneliness, depression, boredom, or emptiness (Dodes & Khantzian, 1991). In the perception of the addicted person, the use of substances "corrects" the feeling of helplessness brought about by an inability to modulate affect. Poor interpersonal relations are associated with these limitations, resulting in the substitution of the chemical for human object relationships. The chemical object has an advantage over a real relationship—it is always available. Hence, many addicted people make comments such as, "Cocaine is my wife," or, "I'm married to the bottle." These ego deficits lead to inadequate "self-care" functions, which is related to low self-esteem and poor anticipation of danger. **Treatment involves exploration of life situations to help clients improve recognition and tolerance of negative affects, develop self-protective behavior, cope with the sense of powerlessness associated with addiction, and gain an understanding of the object meanings of addiction.** This model provides insight into the dynamics of substance use, because relapse research has established that mismanaged emotions are primary precipitants to relapse and that guilt can exacerbate relapse (Marlatt & Gordon,

1985). With dual diagnosis clients, the self-medication model is useful in connecting the use of the substance to underlying symptoms and in identifying the nature of the relationship between the substance and psychological disorder.

BIOPSYCHOSOCIAL MODEL:

The use of the term "biopsychosocial" is common within addiction and psychological treatment, but it typically refers to the combination of interventions within disease-model treatment programs. The **biopsychosocial model**, as stated here, has been proposed by several authors (Chiauzzi, 1991; Donovan, 1988; Zucker & Gombert, 1986) and **stresses the importance of individualized assessment of biological, psychological, and social risk factors**. Each addicted person experiences different combinations of these risk factors; i.e., some people possess high biological loading (e.g., severe physical dependence, family history), whereas others possess high psychological loading (e.g., psychopathologic symptoms, positive expectancies for substance use) or social loading (e.g., family dysfunction, unemployment) (Chiauzzi, 1991). This includes the possibility that an addicted person may have *no* biological loading. **The biopsychosocial approach makes no assumptions about the etiology, progression, or maintenance of addiction. Therefore, the model allows for greater flexibility. This model recognizes the physiologic effects of substances but also places importance upon addicts' perceptions and the social milieu of the drug experience.** Use of this model with the dually diagnosed can also illuminate biological, psychological, and social vulnerabilities to relapse. As a result, it encourages multidisciplinary intervention, including psychological treatment, cognitive-behavioral techniques, and family therapy. The client is taught to balance awareness of and intervention with risk factors rather than to explain difficulties in terms of a single (e.g., biological or disease) process.

Psychotherapy Issues in Dual Diagnosis Treatment

There are five issues that are often overlooked in the psychotherapy of the dually diagnosed: (1) **The nature of denial**; (2) **motivational enhancement**; (3) **protracted withdrawal effects on assessment**; (4) **nicotine addiction and recovery**; and (5) **self-help groups**.

The first issue concerns **denial**, which is typically associated with addiction but is also evident in psychopathologic and even physical disorders. The dual diagnosis client who has been treated within the addiction treatment system may be accepting of an addiction diagnosis but not a psychological diagnosis. The opposite may be true for the dual diagnosis client treated within the mental health system. The former may resist psychological terminology because of expectations that others will view him or her as "crazy." The latter may seek to explore underlying emotional themes without necessarily abstaining from alcohol or drugs. **Substance use can interfere with remission of psychopathologic symptoms, effectiveness of psychotropics, or ability to engage in psychotherapy.** **Lack of compliance with psychiatric treatment or psychotherapy can interfere with recovery from addiction;** e.g., anxiety or depression may increase the desire to use alcohol. The counselor's goal is to educate the client about the "parallel" nature of dual disorders (Minkoff, 1991), which may be enhanced by reviewing past relapses or past symptoms during abstinence periods. In effect, **ignoring either disorder can be construed as a relapse.**

The second issue concerns **motivation**, which may be limited because of the frustrating nature of dual disorders and past relapses with either disorder. Many dual diagnosis clients are ambivalent, indecisive, and conflicted, which may result in a self-fulfilling prophesy of failure. Motivation is usually considered a trait, but it is actually a function of the interac-

tion of the client and counselor (Miller & Rollnick, 1991). The technique known as "motivational interviewing" is based upon five general principles: (1) **Expressing empathy for ambivalence**, which is normal in recovery; (2) **developing discrepancy between present behavior and desired behavior**; (3) **avoiding argumentation**, which can solidify client resistance; (4) "rolling" with resistance by **inviting the client to consider new perspectives**; and (5) **supporting self-efficacy by believing in change and placing the responsibility for change upon the client**. Adopting a collaborative problem-solving approach rather than a confrontational, subjective stance will likely produce more meaningful change. One method that I have found useful is reviewing computerized psychometric test results (e.g., Minnesota Multiphasic Personality Inventory [MMPI], Millon Clinical Multiaxial Inventory [MCMI]), neuropsychological screening measures, and/or addiction inventories with clients. These objective measures provide personalized feedback, and clients can be encouraged to reflect upon *their* interpretations of the results.

The third issue, the **effect of protracted withdrawal on assessment**, is often confusing, because **the psychological symptoms of alcohol and drug withdrawal can overlap greatly with depressive, anxiety, and even psychotic disorders**. Approximately 75% of alcoholics evidence varying degrees of neuropsychological dysfunction (Tarter, Ott, & Mezzich, 1991). In addition to abstract reasoning problems, poor problem solving, impaired short-term memory, and visual-spatial deficits, many recovering people experience insomnia, fatigue, distractibility, mood lability, and irritability. The persistence of these symptoms is particularly troubling to those in recovery, because a high proportion of those in their first 6 months of abstinence experience poor memory, thought blocking, trouble concentrating, or unpleasant thoughts (De Soto, O'Donnell, Allred, & Lopes, 1985). There tends to be a natural course of recovery of cognitive functions with alcoholism. As long-term memory functions (e.g., vocabulary) are generally unimpaired, verbal

learning improves after 2–3 weeks of abstinence, and the ability to retain new information improves after 1–2 months of abstinence (McCrary & Smith, 1986). Abstract reasoning deficits may last even longer, sometimes for years.

Several strategies may be used to clarify psychological assessment early in the recovery process. First, because verbal intelligence functioning (e.g., vocabulary) is not typically impaired, it can be used as a baseline by which other cognitive test results can be interpreted. For instance, if vocabulary scores are above average and short-term memory functioning is below average, the impairment may stem from the substance abuse. Second, assessment should include a review of historical indicators, such as family history of mental disorders, the etiology of psychological symptoms prior to the initiation of addictive behavior, past experience with withdrawal, continuation of symptoms during past abstinent periods, and past responses to psychotropics. Third, repeated assessment through the use of questionnaires such as the Beck Depression Inventory should indicate a gradual decrease of symptoms. Depression is so common in early recovery that clinicians recommend that antidepressant medication not be introduced unless the client has already achieved 4 weeks of abstinence (Brown & Schuckit, 1988). Finally, when using psychometric test results, certain clinical scales such as depression may be elevated because of substance use. Rather than dismissing the test as not representative of actual personality functioning, it is useful to review the results with the client. This exercise can allow the client an opportunity to comment on whether elevations are attributable to personality characteristics or substance abuse—or some combination of the two. The counselor thereby gains information about insight, denial, and substance effects.

The fourth issue, nicotine addiction, is often underestimated because it is not included in discussions of substance abuse. It is noteworthy that 50%–90% of mentally disordered and addicted clients smoke, whereas the rate within the general population

is about 30% (Hughes, Hatsukami, Mitchell, & Dahlgreen, 1986; Istvan & Matarazzo, 1984). There are little data regarding nicotine addiction among the dually diagnosed, but it seems safe to say that **their smoking is significantly greater than among those in the general population. Nicotine can produce psychological changes: low doses can produce stimulation and higher doses can lead to a depressant effect (Benowitz, 1988), so smoking may become a form of self-medication.** Schizophrenics may use nicotine to increase concentration or reduce tension—and may actually require higher levels of psychotropic medication while actively smoking (Goff, Henderson, & Amico, 1992). The prevalence of smoking among anxiety-disordered and depressive clients is high, and smoking cessation may exacerbate such symptoms (Docherty & Chiauuzi, 1993). In fact, **anecdotal reports indicate the potential for an increase in suicidal thinking among depressives who have recently stopped smoking.**

The fifth issue, **self-help groups**, becomes critical because attendance at AA or Narcotics Anonymous (NA) is routinely included in the treatment plans of the dually diagnosed. Involvement in 12-step programs has definite advantages: (1) Such programs provide **a ready-made support group** that can assist in *both* psychological and addiction treatment goals; (2) **the hopeful messages and testimonials of group members can have an “antidepressant” effect**; (3) **unambiguous rules and guidelines may help guide behavior**; (4) clients have an opportunity to **practice development of healthy relationships**; (5) clients can rely on a **broader support system beyond the counselor**; and (6) attendance at groups may prevent relapse with both psychological and addiction problems.

However, attendance at groups is not so simple for those who lack social skills, feel trapped in a group setting, or who have difficulty disclosing personal information. The depressive may be told that he or she is “sitting on the pity pot.” The person with post-traumatic stress disorder (PTSD) may experience anxiety about past events when

reminded by others' "drunkalogues." Because of their diverse needs, **dual diagnosis clients require a more flexible approach to self-help groups than is typically offered** (Chiauzzi & Liljegren, in press). The mental health counselor is therefore encouraged to:

- (1) **Describe the format of self-help meetings**, because they are often confusing to newcomers;
- (2) **provide relevant literature** (e.g., the "Big Book") that explains the philosophy of the groups;
- (3) **employ social skills training such as conversational skills**;
- (4) **discuss the myths of self-help groups** (e.g., that they engage in "brainwashing"); and
- (5) **encourage the client to experiment with different types of meetings** until he or she finds a comfortable combination.

Stages of Psychotherapy with Dual Diagnosis Clients

Because of their complicated presentation, **dual diagnosis clients are best treated in phases**. DiClemente (1991), drawing upon the work of James Prochaska, breaks down the recovery from addiction, psychological states, and psychopathologic disorders into five phases: (1) **Precontemplation**, which is characterized by the "four R's" (reluctance, rebellion, resignation, and rationalization); (2) **contemplation**, in which the client understands the need for change but is ambivalent; (3) **determination**, in which the client has made a decision to change; (4) **action**, in which the client implements a plan and learns appropriate skills; and (5) **maintenance**, which requires relapse prevention skills. Most treatment of the dually diagnosed expends maximal effort during the action phase, but many people "recycle," perhaps by reverting to unhealthy behavior and even returning to a precontemplative stance. Although the action phase takes 3-6 months to complete, the maintenance phase takes a lifetime. Thus, **the bulk of clinical activity should address "staying stopped" rather than stopping addictive or psychological symptoms**.

What are the primary clinical interventions during each of these phases? **During the**

precontemplation phase, the client is not conceptualizing addictive or psychological symptoms, so the counselor should seek to increase cognitive dissonance by providing information and feedback—the more objective the better. Subjective impressions will likely meet with resistance, so formal assessments (psychological testing, laboratory results, information about dual diagnosis problems) may yield better results. Prescribing interventions at this stage (e.g., attending AA) will probably be unsuccessful because the client has not yet determined that there is a problem that requires intervention.

Even though the client may then enter the contemplation phase (agreeing that there is a problem), there may still be much ambivalence about change. The counselor's goal should be to highlight the negative aspects of the addiction, enhance the positive aspects of recovery, remove barriers to change (e.g., facilitating an understanding of the withdrawal process, and increase self-efficacy through contact with similar people who have successfully made changes. Active intervention at this stage may prove too daunting to an ambivalent person.

The client who has worked through his or her ambivalence will then enter the determination phase, which calls for a statement of commitment to change. The task of the counselor at this point involves exploration and specification of a plan; e.g., a treatment contract. Typical provisions would be: (1) Agreement on a method of detoxification; (2) specification of amount and type of educational, psychotherapeutic, rehabilitative, and self-help interventions; (3) inclusion of family members in educational and therapeutic activities; (4) if necessary, random drug/alcohol screening; (5) agreement to take psychotropic medications as prescribed; and (6) avoidance of substitute addictive substances or behaviors.

Once intervention begins, the action phase is underway. It is important to inform

the client that this phase is only a beginning and that the notion of "cure" should be dismissed. Many dual diagnosis clients respond favorably to early interventions and then assume that their active steps can be discontinued. Such impatience can easily induce relapse with either or both of the disorders, so the counselor should emphasize that the recovery process requires an extended period of intervention and monitoring to determine if enduring changes have been established. Other clients expect "overnight" revelations that will provide automatic relief. The concept of recovery as a lifestyle change rather than as a reduction of symptoms should be stressed.

Finally, ongoing change will require maintenance strategies in the form of relapse prevention. As stated earlier, severe psychopathologic disorders are the most accurate predictors of relapse, so clients should be educated about the potential for relapse. Identification of high-risk situations, unresolved emotions (e.g., resentment, anxiety, depression), and negative personality patterns will help the client monitor relapse risk. In many recovering dual diagnosis clients, it may take at least a year to establish abstinence firmly. In early phases, clients may be concerned about coping with drug-using friends, a resurgence of craving, or maintaining their recovery plan. In later phases the primary questions may change to self-actualization, identity, intimacy, long-range goals, review of past trauma, or gaining insight into family and/or relationship issues. Undertaking exploration of these questions too early may actually increase the risk of relapse, so a conservative approach is recommended. This is especially seen with sexual and physical abuse, because current public education may increase the client's desire to resolve residual psychological pain. The counselor can partially satisfy this need by focusing on behavioral manifestations of the abuse while reserving exploration of intense emotional issues for later in the recovery process.

Relapse Prevention with Specific Psychopathologic Disorders

DEPRESSION:

The primary concern with depressed persons who abuse substances (particularly alcohol) is the risk of suicide. The Group for the Advancement of Psychiatry (1991) cites three significant findings: (1) The lifetime risk of suicide among alcoholics is about 15%; (2) alcohol abuse is a factor in about 25%–50% of suicides; and (3) alcohol is second only to affective disorders as a risk factor for suicide in the general population. Suicide assessment is crucial for all depressed substance abusers, even those who deny such tendencies while abstinent. Substance use can lower behavioral controls in those who are prone to depression, so relapse prevention should include identification of high-risk situations for suicidal behavior.

Relapse prevention should be a routine approach during the recovery process for the depressed substance abuser, because time erodes treatment gains. Relapse rates among depressed clients are about 20% by 6 months, 40% by 12 months, and 50% by 24 months (Lavori, Keller, & Klerman, 1984). Several predictors of depression relapse have been identified: (1) Number of previous episodes; (2) frequency of major life events; and (3) a high level of expressed negative emotion by family members (Wilson, 1992). Development of high-quality social support, awareness of high-risk depressive situations, and identification of pleasant events to counter negative life events are important treatment components with these clients.

ANXIETY DISORDERS:

Anxiety disorders are chronic conditions that result in periodic exacerbations and remissions (Barlow, 1988). Pharmacologic treatments (e.g., the use of tricyclic antide-

pressants such as imipramine [Tofranil] and newer agents like fluoxetine [Prozac] and sertraline [Zoloft]) result in a relapse rate of approximately 35%–40%, whereas about 25%–40% of clients fail to show a significant treatment response with behavioral (e.g., cognitive-behavioral) therapy (Brown & Barlow, 1992). **Even among those who do benefit from treatment, many continue to experience anticipatory anxiety and avoidance behavior.** As a result, **they should be prepared to view outcome with anxiety somewhat differently than outcome with addiction;** i.e., complete abstinence may not be possible. **The inclusion of the spouse in the treatment of anxiety disorders should be considered as a means of improving outcome,** because it may reduce dropout and facilitate practice of anxiety-reduction skills, such as exposure to arousing situations and relaxation techniques (Brown & Barlow, 1992).

Another important consideration with anxiety-disordered substance abusers involves **the addictive nature of minor tranquilizers.** Mental health counselors should consult with the client's prescribing physician to ensure every effort is made to consider nonaddictive medications, because addiction-prone persons have high potential for abusing drugs such as diazepam (Valium), chlordiazepoxide (Librium), and alprazolam (Xanax). Psychological approaches should be fully explored, even if anxious clients fixate on a medication solution. Barlow's (1988) exposure-based behavioral treatment or the cognitive therapy approach of Beck and Emery (1985) offer viable alternatives.

SCHIZOPHRENIA:

Because of its debilitation, the counselor might easily ignore substance abuse problems associated with schizophrenia. Deinstitutionalization has left many schizophrenics to fend for themselves, resulting in involvement for many in substance abuse. **Schizophrenic clients lack many of the qualities that lead to a favorable treatment outcome;** e.g., cognitive skills, social support, insight, stimulating activities, stable living arrange-

ments, motivation, and employment. They also **lack the communication skills** to respond to social pressure, do not seek help to cope with craving, or cannot explain underlying emotions that relate to substance use. As a result, **treatment must be more flexible, comprehensive, multidimensional, and long-term than with other dual diagnosis conditions.** For instance, **schizophrenics may have difficulty agreeing to abstinence** as a condition of treatment and may need a period of "engagement" for months before they submit to intervention (Mueser, Bellack, & Blanchard, 1992). Some traditional recovery philosophies such as confrontation and the absolute prohibition against *all* medications do not fit this group, because such beliefs may create strong and unmanageable affect. **The focus instead is placed upon persuasion, support, education, skill building, and development of a social network.** Twelve-step involvement, although challenging for this population, should not be ruled out. Counselors should openly discuss differences between psychological and self-help philosophies, but they should frame these groups as support systems for both the addiction and schizophrenia.

PERSONALITY DISORDERS:

Untreated personality disorders can contribute to relapse, but because the focus of current addiction treatment is placed upon the ill-conceived notion of "addictive personality," (Chiauzzi & Liljegren, in press) little attention is given to these disorders. **A careful diagnosis of personality disorders can yield a rich source of data regarding relapse potential. In addition, the way people relapse can conform to their personality style.** Antisocial personalities may reject feedback; paranoid personalities may resist self-disclosure; dependent personalities may rely on others to maintain their recovery plans; passive-aggressive personalities may harbor resentments; avoidant personalities may feel threatened in self-help groups; and compulsive personalities may seek excessive control and predictability in the recovery process. It is therefore critical to evaluate the manner in

which the personality style interacts with relapse risk factors to foster a return to psychopathologic symptoms or substance use.

Summary

The dual diagnosis problem is both prevalent and complex. The dually diagnosed comprise as much as 80% of substance abuse populations and 30%–50% of psychiatric populations. These figures represent a challenge for any counselor working with clients who are abusing a substance and/or experiencing a psychological disorder. But the real challenge with dual diagnosis clients is understanding the combinations by which psychopathology and addiction may coexist. Not only can clients with the combinations outlined in this lesson present in similar ways, but they can do so for different reasons.

This lesson has outlined relationships that constitute dual diagnosis problems, treatment models, psychotherapeutic issues, stages of psychotherapy, and relapse prevention in an effort to familiarize therapists with the dual diagnosis problem and to make concrete recommendations as dual diagnosis clients progress through various stages of treatment. Counseling strategies tend to vary depending upon the combination of a dual diagnosis and the severity of addiction and pathology. Therefore, it is imperative that mental health professionals understand all aspects of the dual diagnosis problem—not only to implement more effectively the appropriate treatment goals, but also to explain clearly to a particular client the therapeutic process as it relates to his or her dual diagnosis. This way, the counselor and the client will be empowered to work as a team in the recovery process and subsequent relapse prevention.

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Questions Based on this Lesson

25. According to the author, the best predictor of relapse in addiction is:
- A. Employment status
 - B. Tolerance to psychoactive medications
 - C. The severity of any psychological disorder(s) present
 - D. Level of education
26. Which of the following statements is correct?
- A. Dual diagnosis clients are often treatment noncompliant
 - B. Traditional psychological and chemical dependence approaches and assumptions always meet the treatment needs of the dually diagnosed
 - C. In the treatment of the dually diagnosed, intervening in the early phases of recovery with psychodynamic psychotherapy is never counterproductive
 - D. The addictive nature of minor tranquilizers is the most important consideration with schizophrenic substance abusers
27. The biopsychosocial treatment model:
- A. Discourages multidisciplinary intervention
 - B. Emphasizes improving the recognition and tolerance of negative affects
 - C. Stresses the importance of individualized assessment of biological, psychological, and social risk factors
 - D. Makes assumptions about the etiology, progression, or maintenance of addiction
28. Risk of suicide is the primary concern for which type of dually diagnosed clients?
- A. Schizophrenics
 - B. Those who are clinically depressed
 - C. Anxiety-disordered persons
 - D. Those suffering with personality disorders

Directions in Mental Health Counseling

VOLUME 3 • LESSON 8

Aggression Replacement Training in Children and Adolescents

Barry Glick, PhD, NCC

Dr. Glick is Associate Deputy Director of Local Services
at the New York State Division for Youth, Rensselaer, NY.

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Editor's Note

Aggression is learned from a very young age. A 1987 study of television programming observed an average of 13 violent acts per hour during prime time hours, and 32 such acts per hour during Saturday morning cartoons. Whether such programming leads conclusively and inevitably to youth aggression has not been determined, but it nevertheless represents a societal validation of these acts, at least on some level. Moreover, many youth have no access to positive role models or environments that in any way teach or reinforce constructive behavior; thus, many fail to develop such behavior.

Aggressive youth are characteristically lacking in personal, interpersonal, and social cognitive skills that collectively constitute effective prosocial behavior. They are less likely to negotiate and compromise, or otherwise respond appropriately to conflict. They lack the skills necessary to deal with frustration, relying instead on impulsive and aggressive means for goal attainment; and they tend to possess more egocentric, concrete, and primitive levels of moral reasoning.

To deal with the problems of youth violence, Dr. Glick and colleagues have developed a unique program, Aggression Replacement Training (ART), which has been implemented worldwide in the therapeutic rehabilitation of aggressive youth. ART is a differential intervention program that seeks to retrain youngsters in appropriate social skills, anger control, and moral reasoning. The program consists of three components: Structured Learning Training (SLT), Anger Control Training (ACT), and Moral Education (ME). SLT is a 50-skill curriculum that teaches social skills through modeling, role playing, performance feedback, and transfer training. ACT teaches youth to monitor internally and control violent responses by identifying triggers and cues to anger, and using reminders, reducers, and self-evaluation. ME, employed in a discussion group context, is designed to increase the level of moral reasoning used when evaluating an aggression-provoking situation.

This lesson introduces the mental health professional to ART and explains many of the methodologies employed so that they may be replicated and used in a variety of therapeutic settings.

Introduction

Aggression: any action an individual takes against another person that results in injury; or any action an individual takes against property that results in damage.

We live in an aggressive and violent society. While most of us do not fancy ourselves as hostile or aggressive—certainly not violent—we do indeed exist in a basically hostile world. We teach aggression to our youngsters in our homes, in our churches, in our schools. **Aggression pays!** Americans learn at a very early age that aggression is immediately, richly, effectively, and efficiently rewarded. Furthermore, most of us experience various forms of aggression so frequently that we are desensitized to its effects on our own growth, perceptions, values, and attitudes. Conditions that promote aggression are summarized in Table 1.

The Sociology of Aggression

Aggression and hostility are so prevalent in our society that by the time a child reaches adolescence, chances

are he or she will commit some act of delinquency within two years of the onset of puberty. Even though the youth population has declined, the rate of juvenile delinquency and youth aggression has increased and has become even more severe. Juvenile arrests grew 300% from 1975 through 1978 (Table 2), almost twice the adult criminal rate. Males were more delinquent than females at a rate of 4:1.

Table 2
JUVENILE ARRESTS
(FBI CRIME INCIDENTS REPORT, 1975–1978)

<i>Crime</i>	<i>Increase (%)</i>
Total arrests	300
Robbery	376
Aggravated assault	249
Homicide	211

Table 1
CONDITIONS THAT PROMOTE AGGRESSION

- Weak familial or social bonding
- Being a frequent target of aggression
- Observation of successful acts of aggression
- Positive reinforcement of aggressive acts
- Deficiency in information processing skills
 - Ability to identify means-ends relationships
 - Ability to generate alternative solutions
 - Ability to generate consequences
 - Overattribution of hostile intentions
 - Belief that aggression is legitimate behavior
 - Belief that aggression increases self-esteem
 - Belief that aggression yields positive tangible results for self and significant others
- Deficiency in moral reasoning (the capacity to view the world in terms of justice and fairness)
- Deficiency in identifying and using alternative prosocial skill competencies in anger-producing situations

The most frequent violent crime committed by males is robbery; for females, it is aggravated assault. The average age for a first arrest is 13 years. African-American youth are arrested five times more than white youth (violent crimes, 3:1; and theft, 11:1). Juvenile aggression is more likely to occur in urban rather than rural settings. Juveniles are more likely to act in groups, less likely to use a gun, and equally likely to use a knife or some other weapon. The victim of juvenile criminal aggression is seven times more likely to be another juvenile rather than an adult, female rather than male, older rather than younger, a person of color rather than white, poor rather than wealthy, and an acquaintance rather than a stranger.

The Psychology of Adolescent Aggression

Recent research reveals four primary traits that are characteristic of aggressive youth: verbal and physical aggression, skill deficiency, immaturity, and withdrawal.

VERBAL AND PHYSICAL AGGRESSION:

Quay (1983) studied adolescent behaviors using multivariate analysis, and developed a classification for aggressive children. He found that aggressive children could be identified by such behaviors as **fighting, disruptiveness, profanity, irritability, quarrelsomeness, defiance of authority, irresponsibility, high levels of attention-seeking, and low levels of guilt feelings**. Quay observed active antisocial aggressiveness that resulted in conflict with parents, peers, and social institutions.

SKILL DEFICIENCY:

Most behaviorally disordered (aggressive) adolescents are skill-deficient; that is, they **have not developed the social skills necessary to successfully negotiate their environments**.

IMMATURITY:

These behaviors include having a **short attention span, clumsiness, preference for younger playmates, passivity, daydreaming, and incompetence**. **Immaturity often leads to alienation from peers**. By definition, these behaviors represent patterns that may have been appropriate at earlier stages of development, but are not acceptable for the adolescent. In the case of conduct disorders, immaturity leads to attacks on others or withdrawal (in the cases of personality disorders).

WITHDRAWAL:

Behaviors linked to withdrawal have been variously labeled as "personality problem" (Patterson, Reid, & Jones, 1975), "disturbed neurotic" (Quay, 1983), and "overinhibited," and are characterized by **depression, feelings of inferiority, self-consciousness, shyness, anxiety, hypersensitivity, seclusiveness, and timidity**. While withdrawal is not ordinarily associated with aggression, it certainly lends itself to the aggressive adolescent, and is often clinically diagnosed as a component of the passive-aggressive personality.

Aggression Replacement Training (ART): A Multi-Modal Response

Effective intervention is differential intervention. Differential interventions ensure that an array of services and programs are available to the aggressive child and adolescent. Once sufficient programming is available, this hypothesis states that different children and adolescents will respond to different counseling methods. The central question that must be addressed in prescriptive programming for the aggressive juvenile is: **Which types of youth, meeting with which types of change agents, for which types of interventions, will yield optimal outcomes?**

Any and every act of aggression has multiple causes, both within and external to the child or adolescent. With regard to internal causes, ample evidence exists to support the belief that **aggressive youth frequently possess a series of interlocking and often reciprocally compounding deficiencies**. They characteristically are weak or lacking in much of the broad array of personal, interpersonal, and social cognitive skills that collectively constitute effective prosocial behavior. Indeed, a major portion of the disruptiveness and overt aggression reflects psychological and social skill deficiencies. **Persons with skill deficiencies often are weak or lack the knowledge and ability to ask rather than demand**. Likewise, they are less likely to negotiate and compromise, or otherwise respond appropriately to conflict rather than **strike out physically**. Moreover, these youth lack the skills necessary to handle frustration; to respond effectively to the complaints, anger, instructions, or accusations of others; or to behave competently in other important personal and interpersonal arenas. Their frequent impulsiveness and overreliance on aggressive means for goal attainment often reflect a deficiency in anger control.

In the cognitive realm, **aggressive youth** have consistently been shown to **reason at more egocentric, concrete, and primitive levels of moral reasoning**. Al-

though there are many other internal and external antecedents of aggressive behavior than those we address in Aggression Replacement Training (ART), we predicted that much of the outcome variance associated with efforts to change such behavior would occur in the domains of **enhanced prosocial skill proficiency, heightened anger control, and more advanced levels of moral reasoning.**

ART—Research and Evaluation

The ART plan developed by Glick and Goldstein (1987) has become a significant intervention for aggressive, acting-out children and adolescents. Since the original program, ART has been evaluated independently in several jurisdictions with comparable results.

We developed and implemented ART at the Annsville Youth Center, a New York State Division for Youth residential facility for boys who range in age from 14–17 years. They had committed such crimes as assault, burglary, auto theft, possession of stolen property, criminal trespass, and drug use. Annsville is situated in a rural area of New York State, and occupies 30 acres of a 100-acre reserve formerly used as a state forestry camp. At the time of the project, 60 young men were in residence. The median age was 15; the ethnic background of the group was 50% African-American, 40% Caucasian, 8% Latino, and 1% Native American. Approximately half came from New York City, the other half from the rest of the state.

The research plan first involved pretesting the population of 60 boys in a dormitory area that was organized into 5 units of 12 boys each. Units were randomly assigned to experimental and appropriate control conditions. We posttested the boys to ascertain change, and then internally replicated the test for efficacy by providing ART to those youngsters who had been in the control groups, to see if they, too, changed on the several outcome measures. This overall evaluation sequence subsequently was replicated in its entirety, involving a maximum secu-

rity center for youth incarcerated for such crimes as murder, rape, manslaughter, sodomy, arson, and aggravated assault. The program then was designed to be implemented in the community for youth who were returning to their communities on after-care status (parole-type services) and who were being evaluated there as well.

The five units were randomly assigned to three evaluation conditions. Two units (condition 1) were assigned to a full course of ART, which is comprised of three basic components: **Structured Learning Training (SLT), Anger Control Training (ACT), and Moral Education (ME).** The 24 youths, in groups of six each (all groups came from within—never across—units) for SLT and ACT, and 12 each for ME, met for 30 classes over 10 weeks. **Two other units, also a total of 24 youths, were assigned to a “brief instructions” control group (condition 2).** This condition was designed to control for the effects of trainee motivation; that is, changes in a more skilled direction should not be attributed to ART unless such changes can be shown to exceed those associated with simple motivational enhancement. **The 24 youngsters assigned to the “brief instructions” control group were pretested, participated only in usual facility activities—not ART—and then were posttested 10 weeks later at the same point in time as youngsters who received ART.** Just prior to their posttest, however, the “brief instructions” youngsters were provided with test instructions designed to enhance their display of skilled behavior; i.e., instructions about the nature, value, and utility of the skills involved, and especially the desirability of reflecting these skills in their posttest responses.

An important intervention evaluation question one may pose is **whether the intervention is superior in its effect to no intervention at all.** The answer to this question is made possible by the “no treatment” control group. Thus, 12 youngsters (one unit) were assigned to this condition and received pretesting and posttesting only, with no ART intervention or motivational instructions.

We provided all youngsters with a battery of tests to capture the types of behaviors possible as a result of ART. Project data were analyzed by means of a series of 1 x 3 analyses of covariance, controlling for initial status on each variable examined. We found that **youngsters who completed ART, in comparison to those who experienced either motivation enhancing but no training experience, or no training, changed significantly on all study outcome criteria. They both acquire and transfer structured learning skills to a degree significantly beyond that acquired and transferred by control-conditioned youth. ART youngsters also change significantly for the better in their own behavior in the facility.** In terms of both the number of acting-out incidents and the intensity of those that did occur, ART youngsters performed significantly better than controls.

Our community program enhanced our knowledge of dealing with aggressive children and adolescents. We found that **ART youth recidivated less than those who did not undergo ART.** We also found that **youth who participated with their significant others dramatically reduced their risk of recidivism over a 6-month period** (Goldstein & Glick, 1989).

Structured Learning Training (SLT)

Structured Learning Training (SLT) is a psychoeducational intervention designed by Glick and Goldstein (1987) in which a **50-skill curriculum of prosocial behaviors is systematically taught to small groups of chronically aggressive adolescents** (Table 3). The SLT curriculum is preferably implemented with 6–8 adolescents in a group.

The techniques we use to teach children and adolescents social skills training are founded upon sound pedagogy that is used to teach any behavioral skill. If I wanted to teach my 17-year-old son how to drive, I would first take him into my car and *show* him (modeling) how to

place the key in the ignition, ensure the car was in neutral, turn on the ignition, and coordinate the flow of gas with the raising of the clutch so as to properly engage the car into first gear, and so on. I would then ask him to *try* (role playing) what he was shown. I would then provide an opportunity for *discussion* (performance feedback), to give constructive criticism of his performance. Finally, I would give him an opportunity to *practice* (transfer training) what he had learned. We do nothing more when facilitating both the skill training and anger control components of SLT.

MODELING:

Modeling exercises serve to demonstrate examples of expert use of behaviors constituting the skills in which the youngsters are weak or lacking. During the modeling sequence, the facilitator ensures that **the modeling display is presented to trainees in a clear and unambiguous manner.** The display should depict the behavioral steps that constitute the skill being taught. **All the steps that make up the skill should be modeled in their correct sequence.** Modeling consists of **live vignettes enacted by the trainers.** Audio or visual tapes may be substituted as the modeling display, although it is not as effective as live demonstrations. The trainers should always rehearse the vignettes prior to each session and ensure that all the skill's steps are in proper sequence and enacted correctly. **Modeling displays should incorporate at least two examples of different situations for each skill being demonstrated.** If a given skill is taught in more than one group meeting, the facilitator should develop the corresponding number of modeling displays, taking care to select situations relevant to the trainees' real-life circumstances. The main actor (the person enacting the behavioral steps of the skill) should be portrayed as a person who is reasonably similar in age, socioeconomic background, verbal ability, etc., to the participants in the structured learning group.

For clarity and ease of understanding, **modeling displays should depict only one skill at a time and should**

Table 3
THE STRUCTURED LEARNING SKILL CURRICULUM

GROUP I: BEGINNING SOCIAL SKILLS

- | | |
|----------------------------|-----------------------------|
| 1. Listening | 5. Saying "thank you" |
| 2. Starting a conversation | 6. Introducing yourself |
| 3. Having a conversation | 7. Introducing other people |
| 4. Asking a question | 8. Giving a complaint |

GROUP II: ADVANCED SOCIAL SKILLS

- | | |
|-------------------------|----------------------------|
| 9. Asking for help | 12. Following instructions |
| 10. Joining in | 13. Apologizing |
| 11. Giving instructions | 14. Convincing others |

GROUP III: SKILLS DEALING WITH FEELINGS

- | | |
|--|--------------------------|
| 15. Knowing your feelings | 19. Expressing affection |
| 16. Expressing your feelings | 20. Dealing with fear |
| 17. Understanding the feelings of others | 21. Rewarding yourself |
| 18. Dealing with someone else's anger | |

GROUP IV: SKILL ALTERNATIVES TO AGGRESSION

- | | |
|------------------------|----------------------------------|
| 22. Asking permission | 27. Standing up for your rights |
| 23. Sharing something | 28. Responding to teasing |
| 24. Helping others | 29. Avoiding trouble with others |
| 25. Negotiation | 30. Keeping out of fights |
| 26. Using self-control | |

GROUP V: SKILLS FOR DEALING WITH STRESS

- | | |
|----------------------------------|--|
| 31. Making a complaint | 38. Responding to failure |
| 32. Answering a complaint | 39. Dealing with contradictory messages |
| 33. Sportsmanship after the game | 40. Dealing with an accusation |
| 34. Dealing with embarrassment | 41. Getting ready for a difficult conversation |
| 35. Dealing with being left out | 42. Dealing with group pressure |
| 36. Standing up for a friend | |
| 37. Responding to persuasion | |

GROUP VI: PLANNING SKILLS

- | | |
|------------------------------------|--------------------------------------|
| 43. Deciding on something to do | 47. Gathering information |
| 44. Deciding what caused a problem | 48. Arranging problems by importance |
| 45. Setting a goal | 49. Making a decision |
| 46. Deciding on your abilities | 50. Concentrating on a task |

depict all behavioral steps of the skill in the correct sequence; all extraneous content should be eliminated. It is also important that all displays depict positive outcomes. As the modeling display is performed by the trainers, "skill cards," (pocket-sized cards given to each group member to carry with them during the week to refer to as they practice their assignments), which contain the

name of the skill and its steps, are distributed prior to the modeling display. Trainees are told to watch and listen carefully as the models portray the skill. The trainer/facilitator tells the group that sometimes, in order to depict some of the behavioral steps in certain skills, the actors will occasionally engage in "thinking out loud" statements that would ordinarily be thought silently.

ROLE PLAYING:

Role playing provides several guided opportunities to practice and rehearse competent interpersonal behaviors. Role playing should immediately follow the modeling display, and should relate the modeled skill to the lives of the trainees. **First, invite comments on the behavioral steps and how these steps might be useful in real-life situations that the trainees themselves might encounter. Second, focus on current and future skill use rather than only past events or general issues that involve the skill.**

Once a trainee describes a situation in which the skill would be useful, that person is designated the "main actor." The trainee selects a second trainee as a "co-actor" to play the role of the other person in their life who is relevant to the situation (e.g., mother, peer, staff member, etc.). **Be sure to encourage the trainee to choose someone that resembles the real-life person in as many ways as possible** (e.g., physically, expressively). Then, solicit additional information to set the stage for the role playing; i.e., a description of the physical setting, events immediately preceding the role play, a description of the manner that the co-actor should display, and any other information to **increase a sense of reality.**

The facilitator/trainer should **review the steps of the skill with the actor** and make sure the actor understands how the steps are to be applied to the role play. Tell the actor to refer to the skill card and assign other group members to watch the role playing and ensure that the steps are being completed. The trainer should ensure that the co-actor stays in his or her role, and also coaches the observers on the cues to watch by his or her posture, tone of voice, and content of speech. The facilitator may break the role playing and start again, giving the necessary instruction or reinstruction before restarting. (Remember, in **Aggression Replacement Training**, we are interested in *practice of perfect*, not *"practice makes perfect."*) One facilitator/trainer should be positioned near the chalk board pointing out each step as it is role-played. A second facilitator/trainer should be strategically seated with the group to help the members with

the tasks at hand or to maintain order. Role playing continues until all participants have an opportunity to be a main actor. Sound group role-playing techniques can be employed, such as "role reversal" (where the actor and co-actor switch roles); with hesitant clients, the trainer may assume the role of the co-actor.

PERFORMANCE FEEDBACK:

Performance feedback is a discussion period that provides praise, reinstruction, and related feedback on how well the adolescent's role playing of the skill matched the expert model's portrayal of it. It also examines the psychological impact of the enactment on the co-actor and provides the main actor with encouragement to try out the role-played behaviors in real-life situations. The facilitator first should ask the co-actor about his or her reactions, then have the observers comment on how well the behavioral steps were followed. Next, trainers should comment on how well the behavioral steps were followed and provide social reinforcement (praise, approval, encouragement). During this activity, the facilitator should **follow sound reinforcement techniques** as in any good behavioral feedback session. That is, **provide reinforcement only after role plays that follow the behavioral steps, and at the earliest appropriate opportunity; vary the specific content of the reinforcements.** For example, praise particular aspects of the performance such as the tone of voice, posture, and phrasing; provide enough role playing activity for each group member to have sufficient opportunity to be reinforced; provide reinforcement in an amount consistent with the quality of the given role play; **provide no reinforcement when the role playing departs significantly from the behavioral steps** (except for "trying" in the first session or two); provide reinforcement for an individual trainee's improvement over previous performances; and always provide reinforcement to the co-actor for being helpful, cooperative, and willing to try. The trainer should focus on behavioral structured learning components. Comments should reflect concrete behaviors, not general evaluations. Negative comments

should always be followed by a constructive comment as to how a skill or step should be improved. Poor performance may be reinforced simply by saying, "Good try." Trainees who fail to follow the behavioral steps of the skill should be given the opportunity to role play the same behavioral steps after receiving corrective feedback.

TRANSFER TRAINING:

Transfer training, or practicing, encourages youth to engage in a series of activities designed to increase the chances that the skill learned in the training setting will endure and be available for use when needed in the environment, whether it be the institution, home, school, community, or other real setting. The general principles to implement transfer training start with the trainer providing the trainees elementary understanding of basic stimulus-response relationships operating in the training and real-world environments. Thus, one should provide the trainees' information visually, verbally, and in writing. Three principles that are particularly useful in transfer training are: overlearning, identical elements, and positive transfer.

Overlearning:

Overlearning involves training in a skill beyond what is necessary to produce initial changes in behavior. In both structured learning and anger control groups, overlearning is substantial for each skill taught. Its behavioral steps are modeled several times, role played one or more times by the trainees, observed live by the trainee as every other group member role plays, read by the trainee from a chalk board and a skill card, and practiced in real-life settings one or more times by the trainee as part of the formal homework assignments.

Identical Elements:

Another principle involved in transfer training is what we call "identical elements." The greater the similarity of physical and interpersonal stimuli in the group setting, as well as the homework and community or other

setting in which the skill is to be applied, the greater the likelihood of transfer. The trainer may ensure that the structured learning or anger control setting is more similar to real life settings by: **designing the live modeling displays to be highly similar to what trainees face in their daily lives** through the representative, relevant, and realistic portrayal of the models, protagonists, and situations; **designing the role playing to be similar to real-life situations** through the use of props, the physical arrangement of the setting, and the choice of realistic co-actors; **conducting the role play to be as responsive as possible to the real-life interpersonal stimuli to which the trainees must actually respond later with the given skill**; **rehearsing each skill in role plays as the trainees actually plan to use it**; and **assigning homework**.

Positive Transfer:

Positive transfer of skills is greater when a variety of relevant training stimuli are employed; we call this "stimulus variability." To apply this principle to structured learning and anger control groups, one should **rotate group leaders across groups, rotate trainees across groups, role play a given skill with several different co-actors, role play a given skill by trainees across several relevant settings, and complete multiple homework assignments for each given skill.**

Anger Control Training (ACT)

Anger Control Training (ACT) was first developed by Feindler, Marriott, and Iwata (1984), and was partially based on the earlier anger control and stress inoculation research of Novaco (1975) and Meichenbaum (1977). The goal is to **teach youngsters the inhibition of violent responses**. In ACT, each young person is required to bring to each session a description of a recent anger-arousing experience (a hassle), which they record in a binder (their hassle log). For 10 weeks, **the youngsters are trained to respond to their hassles with a chain of behaviors that include:**

- **identifying triggers** (external events and internal self-statements that provoke anger responses)
- **identifying cues** (individual physical events such as tightened muscles, flushed face, and clenched fists that let the child or adolescent know that the emotion he or she is experiencing is anger)
- **using reminders** (self-statements such as "stay calm," "chill out," "cool down," or non-hostile explanations of others' behavior)
- **using reducers** (a series of techniques that, like the use of reminders, is **designed expressly to lower the individual's level of anger**—such as deep breathing, counting backward, imagining a peaceful scene, or imagining the long-term consequences of one's behavior)
- **using self-evaluation** (reflecting on how well the **hassle was responded to** by identifying triggers, identifying cues, using reminders, and using reducers; and then **praising or rewarding oneself for effective performance**)

Young people who have participated in SLT and ACT are knowledgeable about what to do and what not to do in circumstances that instigate aggression. However, because aggressive behavior is so consistently rewarded in many of the real-world settings in which children and adolescents live, work, go to school, and interact, **they may still consciously choose to behave aggressively.** Thus, we believed it was important to add a values-oriented component to the intervention approach that they were developing and evaluating.

Moral Education (ME)

The Moral Education (ME) component of Aggression Replacement Training is a set of procedures designed to **raise the young person's level of fairness, justice, and concern with the needs and rights of others.** In a long and pioneering series of investigations, Kohlberg (1969, 1973) demonstrated that exposing youngsters to a series of moral dilemmas (in a discussion group context in which youngsters reason at differing levels of moral thinking) arouses an experience of cognitive conflict, the resolution of which will frequently advance a youngster's reasoning in the group. Such advancement of moral reasoning is a

reliable finding, but, as with other single-enhancing interventions, efforts to use it alone as a means of actual, overt moral behavior have resulted in only mixed success (Arbuthnot & Gordon, 1983; Zimmerman, 1983). We suggest a need for increasing adolescents' levels of moral reasoning because **such youth did not have in their behavioral repertoires either the actual skills for acting prosocially or for successfully inhibiting antisocial or more aggressive behaviors.** Thus, we reasoned that Kohlberg's Moral Education has marked potential to provide constructive direction toward sociability and away from antisocial behavior.

Two trainers meet with at least 12 youngsters in each ME group. Once the groups are formed, **trainers must choose and prepare the moral dilemmas, create a proper environment and attitude, initiate the discussion, guide the discussion, and then end the discussion.** Facilitators are trained to accomplish each of these procedural steps so they may accomplish the following:

Choose and Prepare a Dilemma:

The trainer first should **anticipate how the participants will reason at each stage.** Second, the trainers should **prepare elaborations to generate disagreements** for each dilemma. And finally, the trainers should **prepare at least two counterarguments** for how to deal with the dilemma.

Create the Proper Environment and Attitude:

The facilitator should **ensure that the group is physically and psychologically safe** and secure enough for the participants to share ideas and beliefs openly. The facilitator should then **identify the goals of the group;** i.e., provide explanations for the purpose of ME groups, the group format and members' roles, the leader's role, and the group norms. **Once the goals have been articulated, the trainer should establish group norms** to be followed and **invite group members to identify norms** they wish to follow.

Initiate the Discussion:

The facilitator begins by passing out copies of a moral dilemma, and reads or has a group member read the dilemma to the group. The major points of the dilemma then are summarized through brief group discussion. The trainer should encourage questions from the group that help make the dilemma more clear. The facilitator then should clarify questions, problems, or misconceptions about the dilemma.

Guide the Group Discussion:

The leader begins the moral education discussion by obtaining initial opinions from each resident and their rationale for their positions. (It is critical to keep this part brief.) The trainer then rephrases or paraphrases each participant's rationale, writes a short summary of initial rationales on newsprint or a chalkboard (the purpose for these procedures is to "stage" each participant so the leader may direct discussion), and conducts a "differing opinions debate."

End Discussion:

The facilitator should summarize debates for each pair of debaters or for each group, and should present an argument at one stage higher than the most sophisticated or abstract argument presented. Again, keep in mind that *there are no right or wrong answers*. The objective for the ME sequence is to expose individuals to higher order or levels of moral reasoning.

Practical, Ethical, and Legal Considerations

Aggression Replacement Training has been designed to be culturally and ethnically neutral. As such, it may be used in any type of environment with homogeneous or heterogenous, culturally diverse clients. Language barriers may be overcome through translation.

When dealing with violent children and adolescents, the same precautions and ethical standards need to be applied as in any other counseling modality. While

confidentiality must be honored, participants must understand—and the group norms must reflect—that the group and its members are guaranteed their safety and security. Therefore, any information that would lead to harmful conditions to group members or others will not be held in confidence. For example, if through the group process the counselor obtains information that a client will commit an act that is in violation of the law, the counselor is obligated to inform the police. If a client threatens harm to himself or herself, the counselor is obligated to refer that information to the appropriate source (in the case of nonreferral, counselors may be held liable for aiding and abetting criminal activities of juvenile delinquents). Finally, as counselors deal with adjudicated youth, or others who are deemed a threat to society by their aggressive or violent nature, they need to be well-versed in the laws within their jurisdictions that govern their clients.

Summary

Aggression is a complex, multifaceted, learned, behavioral response. Children and adolescents have become more aggressive, with greater incidence and intensity over the last three decades. Counselors need to identify and implement appropriate multi-modal treatment interventions to modify the attitudes and behaviors of their aggressive clients.

The purpose of this lesson is to give mental health professionals an opportunity to explore the nature of aggression in children and youth, identify the principles of aggressive behavior, and learn, in detail, about one intervention that has been successfully developed, implemented, and evaluated.

For mental health professionals, it is imperative to implement professional treatment skills to deal adequately with the growing problem of youth violence. It is equally important to take the time to evaluate new programs and treatment services offered so that we can further develop and enhance the quality of professional tools available.

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Questions Based on this Lesson

29. Which of the following has *not* been found to be characteristic of aggressive youth?
- A. Verbal and physical aggression
 - B. Skill deficiency
 - C. Immaturity
 - D. Outgoingness
30. Which of the following statements about the *modeling* component of Structured Learning Training (SLT) is false?
- A. It demonstrates examples of appropriate ways to use SLT curriculum skills
 - B. It consists of live vignettes enacted by the youth in the program
 - C. When modeling, one should depict only one skill at a time
 - D. The modeled scenario should always depict a positive outcome
31. The following steps:
Modeled several times; role played one or more times by the trainees; read by the trainee from a chalk board and a skill card; practiced in real-life settings
are examples of which technique?
- A. Moral Education
 - B. Overlearning
 - C. Identifying triggers
 - D. Identical elements
32. When facilitating a Moral Education discussion, the counselor should:
- A. Ensure that the group is physically and psychologically safe enough for the participants to share ideas and beliefs openly
 - B. Allow the group as a whole to select a topic for discussion
 - C. Refuse to establish any group norms, because they may inhibit discussion
 - D. Provide the "right" answers to the dilemma at the conclusion of the session

Directions in Mental Health Counseling

VOLUME 3 • LESSON 9

Chronic Fatigue Syndrome: Perspectives on Evaluation and Treatment

Mark A. Demitrack, MD

Dr. Demitrack is Director of the Chronic Fatigue Clinic in the
Department of Psychiatry at the University of Michigan, Ann Arbor, MI, and
Director of Clinical Research of the Michigan Eating Disorders Program at that same institution.

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Editor's Note

In the past, the etiology of chronic fatigue syndrome was relegated completely to the psychological realm; any physical component was regarded either as purely hypochondriacal or as separate from the real problem. Thus, the concept that the disease may be treated wholly as a medical disorder was often dismissed. In recent years, information has increasingly pointed to the physical disorders that form the foundations for a diagnosis of chronic fatigue.

To qualify for a diagnosis of chronic fatigue syndrome, a person must have persistent or relapsing debilitating fatigue for at least 6 months in the absence of any medical or psychological diagnosis that would explain the clinical picture. It's long been known that episodes of depression can follow viral infections, and this possibility should be considered by any mental health professional working with clients who have been diagnosed with chronic fatigue syndrome. Depression is common in such clients, whether as a major underlying contributor to the clinical state or as a complication of the loss of normal functioning. When depression is concomitant with chronic fatigue syndrome, it can seriously undermine the recovery process, especially when vocational aspects are being addressed. In this context, depression should be regarded as a challenge that the mental health professional must treat separately, but simultaneously, if the process is to be successful.

Mental health professionals often work with clients who have either actually been diagnosed with chronic fatigue syndrome, or who are convinced that their lethargy and lack of motivation have a physical component. Thus, therapists and counselors should be familiar with the methods currently used to evaluate and treat this disorder, and also know how to recognize signs and symptoms in clients who may need to be referred to a physician for this diagnosis.

Chronic fatigue syndrome seems to be self-limited, although it can go on for months and even years. It calls for close collaboration between the therapist and the client's regular physician. In this lesson, the author reviews the medical basis of chronic fatigue syndrome, including possible infectious and neuroendocrine factors that may contribute to the onset of the disease.

Introduction

This lesson will summarize the condition of chronic fatigue and offer a brief overview of current theories to explain this phenomenon. An argument is made here that treatment planning should play a primary role in a multidisciplinary team approach to this syndrome. The history of chronic fatigue is rich and complex and, in itself, provides interesting insight into the development of the general concept of illness during the rise of industrialization and the emergence of modern medical technology. Because a more thorough treatment of that aspect of the illness is beyond the scope of this lesson, the reader is referred to a number of texts for a more extensive discussion of these issues (Manningham, 1750; Beard, 1869; Wood, 1941; Lutz, 1991).

The syndromal presentation of chronic fatigue, feverishness, diffuse pains, and other constitutional complaints (often precipitated by an acute infectious illness and aggravated by physical and emotional stressors) has received considerable attention in the lay and medical media over the last decade. What is less frequently emphasized is that similar clinical presentations have been described in medical writings since the early 1700s. Sir Richard Manningham (1750) wrote of the "febricula," or "little fever," that presented with a variety of constitutional complaints but few objective clinical findings. One of the more lasting appellations for these symptoms, "neurasthenia," was introduced by George Beard (1869) in the late nineteenth century and is still used today in the 9th Revision of the World Health Organization's International Classification of Diseases. Beard maintained that the etiology of this syndrome resided in subtle and undetectable alterations in neurochemistry, but the pathophysiology of this clinical entity remains unknown more than a century later.

To facilitate identification of objective characteristics and improve comparability of research studies, a study group convened by the Centers for Disease Control (CDC) in 1988 proposed a working case definition, renaming the

illness "chronic fatigue syndrome" (Holmes, Kaplan, Gantz, et al., 1988). Essentially, **clients meeting criteria for the syndrome must have persistent or relapsing debilitating fatigue for at least 6 months in the absence of any medical or psychological diagnosis that would explain the clinical presentation.** Symptom criteria for this syndrome also include **an abrupt onset, low-grade fever, arthralgias** (pains in a joint), **myalgias** (muscular pains), **painful adenopathy** (any disease of the glands, especially of the lymphatic glands), **post-exertional fatigue, neuropsychological complaints, and sleep disturbances** (Table 1). This was the first attempt to bring coherence to a confusing array of names and diagnostic criteria that remain in common use to describe this syndrome.

A number of issues regarding this definition deserve comment. A fundamental emphasis was placed on the systematic exclusion of known entities that, early in their course, could mimic this presentation, such as systemic lupus erythematosus (inflammatory redness of the skin), rheumatoid arthritis, multiple sclerosis, or certain malignancies. Additionally, the absence of discrete laboratory testing that could be used to bolster confidence in the diagnosis of chronic fatigue syndrome was underscored.

What has remained most confusing about this definition has been a clear delineation of confounding mental disorders. **At the present time, a descriptive algorithm for the differentiation of primary mental disorders from chronic fatigue syndrome remains elusive.** Most investigators would agree that **formally diagnosable disorders are present in well over half of all cases** (Taerk, Toner, Salit, Garfinkel, & Ozersky, 1987; Manu, Lane, & Matthews, 1988; Manu, Matthews, Lane, et al., 1989; Kruesi, Dale, & Straus, 1989; Gold, Bowden, Sixbey, et al., 1990; Hickie, Lloyd, Wakefield, & Parker, 1990). **However, the question of whether they are fully explanatory of the clinical presentation, are secondary manifestations of a primary disease process, or are coincident diseases with the fatigue syndrome, modulating its presentation and course, is unanswered.** Indeed, it is precisely because of this latter problem that

Table 1
CENTERS FOR DISEASE CONTROL CASE CRITERIA FOR CHRONIC FATIGUE SYNDROME

Major criteria

(Client must fulfill both major criteria)

- New onset of persistent or relapsing, debilitating fatigue or easy fatigability that does not resolve with bedrest and is severe enough to impair average daily activity below 50% of premorbid activity level, lasting for a period of at least 6 months
- Exclusion of other clinical conditions or medication effects by appropriate history, physical examination, or laboratory tests

Minor criteria

(Client must show 6 or more of the symptom criteria and 2 or more of the physical criteria; or 8 or more of the symptom criteria)

Symptom criteria—must have begun at or after onset of the fatigue and must be persistent or recurring

- Mild fever or chills
- Sore throat
- Painful anterior or posterior cervical or axillary lymph nodes
- Generalized muscle weakness
- Myalgias
- Prolonged post-exertional fatigue
- Headaches
- Migratory arthralgia
- Neuropsychologic complaints (e.g., photophobia, transient scotomata, forgetfulness, irritability, confusion, depression, poor concentration)
- Sleep disturbance
- Main symptom complex having an abrupt onset

Physical criteria—must be documented on at least two occasions, at least one month apart

- Low grade fever (oral temperature 37.6–38.6°C or rectal temperature 37.8–38.8°C)
- Nonexudative pharyngitis (inflammation of the pharynx)
- Palpable anterior or posterior cervical or axillary lymph nodes

all mental health professionals should be primary members of treatment and research teams dealing with this client group.

The Role for Psychological Vulnerability in the Development of Chronic Fatigue

Although the etiology of chronic fatigue syndrome is unclear, two principal theories have dominated previous

attempts at a unifying pathophysiologic model for this syndrome. One set of ideas has focused on the behavioral antecedents of the illness, maintaining that the disorder represents the psychological aftermath of an acute infectious event in emotionally susceptible persons. Indeed, as noted above, it is the prominence of neuropsychological symptoms in the clinical presentation that have contributed significantly to the perplexing and frustrating nature of the illness. Wood (1941) wrote, "...patients should be informed of the nature of their illness and be treated as psychoneurotics; their distaste for this label may prove quite helpful....The patient must be induced to believe that he is suffering from the effects of emotional disturbance and not from any disease or alteration of visceral function...." On the other hand, the alternate view has emphasized the importance of the infectious onset, with constitutional symptoms emerging secondary to persistent immune stimulation and/

or other lasting pathophysiologic changes caused by the initial infectious event. Inadequate attention has been given to how these two views might interface.

A number of seminal studies served to bolster evidence for the first view. In a follow-up study of 65 patients with documented acute brucella infection, Spink (1951) noted that approximately 20% of these patients proceeded to have prolonged symptoms with no objective evidence of continued, active disease. Although he pro-

posed that these symptoms could be attributed to either continuing infection or subtle damage to the central nervous system, Spink (1951) observed a high degree of psychological morbidity in this subgroup of patients. He speculated that "...individuals with functional complaints or personality difficulties may have an exaggeration of these manifestations following acute brucellosis...."

Recently published studies using structured interview techniques have also suggested the prevalence of a mental disorder to be higher in those with chronic fatigue syndrome than in the general population and to often precede the onset of the fatigue syndrome (Taerk et al., 1987; Manu et al., 1988; Manu et al., 1989; Kruesi et al., 1989; Gold et al., 1990). In only one study was the prevalence of a mental disorder reported to be comparable with that of the general population, and to follow, rather than precede the development of the chronic fatigue (Hickie et al., 1990). However, as emphasized in the introduction, in the absence of reliable biological measures to identify this syndrome—and given that most established diagnostic systems often include fatigue and nonspecific somatic complaints as symptoms of a mental disorder, the use of this phenomenologic criteria alone introduces an unavoidable circularity of reasoning when trying to establish a definitive distinction between chronic fatigue and a mental disorder.

Infection and the Development of Chronic Fatigue

Evidence supporting an infectious or persistent immune dysregulation hypothesis for the pathophysiology of chronic fatigue emerged primarily from a series of reports that began appearing between 1982 and 1985. These studies reported a spectrum of subtle abnormalities in cell-mediated and humoral immunity in these patients, along with atypical profiles of antibody responses to the Epstein-Barr virus and other viral antigens (Tobi, Ravid, Feldman-Weiss, et al., 1982; Jones et al., 1985; Straus, Tosato, Armstrong, et al., 1985). Such immunologic disturbances, coupled with the obser-

vation that many of these persons developed the syndrome following an episode of acute infectious mononucleosis, led to the specific hypothesis that the illness was a manifestation of chronic Epstein-Barr virus infection. However, subsequent observations have challenged that idea and suggest that, whereas immune stimulation may be present in these patients, persistent Epstein-Barr virus infection is almost certainly not a tenable explanation for most cases of the syndrome (Horwitz, Henle, Henle, Rudnick, & Latts, 1985; Holmes et al., 1987; Buchwald, Sullivan, & Komaroff, 1987; Straus, Dale, Tobi, et al., 1988).

Nevertheless, it is likely that an acute infectious illness serves as the precipitating event in many, but not all, clients with chronic fatigue syndrome. Although no clear and convincing evidence has emerged to demonstrate a causal relation between infection with any specific viral agent and the subsequent development of chronic fatigue syndrome, several viruses continue to receive attention, especially the herpes viruses, such as Epstein-Barr virus, herpes simplex viruses, human herpes virus type 6, and the enteroviruses (intestinal viruses), such as coxsackie B virus.

It should be emphasized that a role for persistent pathophysiologic changes following an acute viral infection has also not been excluded as a possible pathogenesis of chronic fatigue syndrome. Indeed, Oldstone and colleagues (1986) have provided evidence in animals to demonstrate that viral infections may lead to persistent pathologic changes in differentiated cellular functions long after the infection itself has resolved.

Neuroendocrine Considerations in the Development of Chronic Fatigue

Various forms of neuroendocrine disturbance may also accompany infectious disease in humans and can contribute to the onset of chronic fatigue. For instance, various acute viral infections activate the hypothalamic-pituitary-adrenal axis (Preeyasombat, Richards,

Silverman, & Kenny, 1965; White, Carter, Rector, et al., 1969; Zeitoun et al., 1973); it has been suggested that this is an example of the body acting to contain the infection. In chronic infectious states, such as viral hepatitis or infection with human immunodeficiency virus (HIV), subtle fluctuations in neuroendocrine function may also occur (Kedrowa, 1965; Membreno et al., 1987; Croxson et al., 1989; Schlienger & Lang, 1989; Merenich, McDermott, Asp, Harrison, & Kidd, 1990).

With these considerations in mind, our group has recently suggested that the clinical overlap between chronic fatigue syndrome and a variety of primary mental disorders may reflect the activation of a shared, final common biological pathway precipitated by a variety of infectious or non-infectious pathophysiologic antecedents (Demitrack & Greden, 1991).

First, a review of the clinical presentation of chronic fatigue syndrome shows considerable overlap with that seen in clients with glucocorticoid deficiency (Baxter & Tyrell, 1981). (A glucocorticoid is a hormone of the adrenal cortex that raises the concentration of blood sugar and liver glycogen [a carbohydrate that is converted eventually to glucose].) Indeed, one of the principal symptoms of glucocorticoid deficiency is debilitating fatigue. An abrupt onset precipitated by a stressor, feverishness, arthralgias, myalgias, adenopathy, postexertional fatigue, exacerbation of allergic responses, and disturbances in mood and sleep are also characteristic of glucocorticoid insufficiency (Baxter & Tyrell, 1981).

Physical Deconditioning: A Clinical and Methodologic Confound?

Clients with chronic fatigue syndrome commonly report an exacerbation of symptoms after periods of increased physical activity (Holmes et al., 1988). It is not surprising that the acute infectious illness that often precedes the onset of the fatigue syndrome is associ-

ated with extended periods of physical inactivity. Clients may therefore develop exertional fatigue and intolerance of physical activity as a direct consequence of the prolonged periods of acute, disease-associated inactivity. Whether the physical inactivity may account for some, if not all, of the symptoms and biological findings in clients with chronic fatigue syndrome is not clear.

With respect to the neuroendocrine data noted above, it is of interest that the neuroendocrine system can be affected significantly by the level of physical activity or fitness of the individual. Chrousos and colleagues have demonstrated that highly trained runners have significant elevations in basal glucocorticoids compared with sedentary individuals (Luger, Deuster, Kyle, et al., 1987). Furthermore, these investigators have shown that increasing levels of physical conditioning lead to an adaptation of the exercise-stimulated response of the hypothalamic-pituitary-adrenal axis. Hence, sedentary individuals normally have a more robust stimulation of the pituitary-adrenal response to exercise challenge compared with physically conditioned individuals (Luger et al., 1987). The impaired activation of the hypothalamic-pituitary-adrenal axis that we have reported in those with chronic fatigue syndrome is, therefore, inconsistent with the hypothesis that simple physical deconditioning provides a complete explanation of this syndrome. Furthermore, reports of muscle strength, endurance, and recovery (Lloyd, Phales, & Gandevia, 1988)—as well as the results of biochemical (Byrne & Trunce, 1987), electrophysiologic (Richardson, 1978), and microscopic examinations (Behan, Behan, & Bell, 1985)—have failed to reveal a major disturbance of muscle function in clients with chronic fatigue syndrome. On the other hand, studies of exercise tolerance to aerobic work have shown physiologic measures compatible with prolonged physical inactivity (Riley, O'Brien, McCluskey, Bell, & Nicholls, 1990).

At the present time, no rational basis exists to recommend restriction of the client's level of physical

activity as a therapeutic intervention. Indeed, the bulk of the available data would suggest that, if anything, such a treatment approach might exacerbate the fatigue.

Treatment Trials

Many therapeutic agents have been proposed for the treatment of chronic fatigue syndrome (Gantz & Holmes, 1989) but few formal, double-blind, placebo-controlled trials have been conducted. In replicated studies, no specific agent has been clearly shown to be a successful treatment for chronic fatigue syndrome. The clinical trials that have been performed have been of great help in bringing some degree of reason to the existing treatment recommendations; however, all are plagued by similar methodologic problems. The establishment of a working case definition for the illness has assisted in the comparability of research efforts; nevertheless, several important trials were conducted before this definition was published, and several others continue to employ definitions idiosyncratic to the investigators' local community. These considerations may be of arguable importance, given that the initial CDC definition may not describe a homogeneous group of clients distinct from the larger group of individuals with chronic fatigue (Katon, Buchwald, Simon, Russo, & Mease, 1991). An additional problem in the interpretation of some studies has been the lack of appropriate behavioral descriptors, such as structured psychological interviews or valid and reliable behavioral rating scales. The conspicuous lack of such measures impedes the ability to address the contentious issue of the effect of formal emotional disorders or behavioral symptoms per se on treatment outcome. Finally, uniformly agreed upon measures of treatment outcome—whether biological or behavioral—have not yet been established.

Acyclovir

One of the initial agents to be formally studied for the treatment of chronic fatigue syndrome was the antiviral agent, acyclovir (Zovirax) (Straus et al., 1988). This

agent, which inhibits the replication of the Epstein-Barr virus in vitro (observable in a test tube) and in vivo (within the living body), was chosen at a time when the specific involvement of Epstein-Barr virus in the etiopathogenesis of chronic fatigue syndrome was still in question. Twenty-seven adults were studied in a double-blind, placebo-controlled manner, with a treatment course involving intravenous and oral acyclovir administration. **Similar rates of improvement were seen with both acyclovir and placebo.** Four patients described sustained improvement after discontinuing the treatment; however, in three of the four, the improvement began during the placebo treatment phase.

LEFAC

Kaslow and coworkers (1989) reported the results of a double-blind, placebo-controlled crossover study with **LEFAC, a combination of bovine liver extract, folic acid, and cyanocobalamin (Vitamin B₁₂)**, a therapy was popularly advocated and available in the investigators' community. Similar to the acyclovir results, **a substantial placebo effect was noted**, whereas LEFAC demonstrated no effectiveness in the amelioration of overall symptoms compared with placebo. Two studies, one in the United States (Peterson, Shepard, Macres, et al., 1990) and one in Australia (Lloyd, Hickie, Wakefield, Boughton, & Dwyer, 1990), centered on the treatment response to intravenous immunoglobulin G (IV IgG) in persons with chronic fatigue syndrome in a placebo-controlled fashion. The results were conflicting. The Australian group reported significant efficacy of IV IgG in a 3-month trial; on the other hand, the U.S. investigators reported no effect over a 6-month treatment period. The Australian group also noted that those who improved with active treatment showed improvement in a number of immunologic measures. Certain caveats should be kept in mind in interpreting these results, in particular the issues mentioned above in regard to a lack of agreement on the definition of chronic fatigue syndrome between the two studies, as well as conflicting patterns of outcome measures (i.e., in the

Australian study, the investigators described overall improvement, whereas the patients themselves did not). The investigators were also cautious, advocating the need for further research before definitive treatment recommendations could be established for this agent.

Essential Fatty Acids

In that same year, Behan and colleagues (1990) reported the results of a 3-month, double-blind placebo-controlled trial of **essential fatty acids** (i.e., Efamol Marine, a combination of evening primrose oil and fish oil) in 63 persons with chronic fatigue syndrome. Essential fatty acids have been advocated for the treatment of chronic fatigue on the basis of the putative interactions of essential fatty acid metabolism and viral infections. These investigators reported that, at 3 months, 85% of clients in the active treatment group had shown substantial improvement, and only 17% of placebo-treated subjects had improved. The results have not been examined or confirmed by others.

Magnesium Sulfate

Cox and colleagues (1991) reported on a double-blind, placebo-controlled trial of intramuscular magnesium sulfate. Thirty-two subjects were randomly assigned to either placebo or intramuscular magnesium sulfate weekly for 6 weeks. The investigators reported substantial clinical improvement in the actively treated subjects compared with those receiving placebo. Although of interest, no clear explanation could be given by the investigators for their findings, nor have they yet been replicated. The possibility that magnesium administration may produce a nonspecific energizing effect in normal persons should be excluded before substantive conclusions are drawn from this study.

Antidepressants

Antidepressants have been advocated for the treatment of chronic fatigue syndrome. The rationale for their

use emerges for several reasons. First, **tricyclic antidepressants have been suggested to have efficacy in the treatment of fibromyalgia, a syndrome closely resembling—and possibly identical with—chronic fatigue** (Wysenbeek, Mor, Lurie, & Weinberger, 1985; Carette, McCain, Bell, & Fam, 1986). Second, **pain is a significant dimension of disability in this client group, and these agents have also been suggested to be useful in the treatment of chronic pain states.** Finally, as has been mentioned elsewhere in this lesson, **depression, as a syndrome, is a common accompaniment of chronic fatigue.** Only one study has examined antidepressant treatment, specifically a single case study of the double-blind, placebo-controlled administration of nortriptyline (Aventyl, Pamelor) in a woman with chronic fatigue (Gracious & Wisner, 1991).⁴⁶ Interestingly, it was noted that in addition to the expected improvement of her affective symptoms, she also reported significant amelioration of her physical symptoms such as fever, lymphadenopathy (disease of the lymph glands), and paresthesias (a morbid or perverted sensation, such as burning or prickling).

Cognitive Therapy

A notable nonpharmacologic treatment modality has been an encouraging report of the successful use of **cognitive behavior therapy in an open trial** (Butler, Chalder, Ron, & Wessely, 1991). The investigators argued that in some clients with chronic fatigue syndrome, an initial infectious agent may trigger a spiralling cycle in which "...both attributional and cognitive factors fuel avoidant behaviour...." Their treatment program directs specific attention to the treatment of an underlying mood disorder, if it exists, along with specific attention to cognitive distortions emerging from unfounded ideas about the illness, and finally, reducing patterns of behavioral avoidance. **Although promising, those observations await more formal assessment and independent replication.**

A Proposed Program of Clinical Evaluation and Treatment Planning

Chronic fatigue syndrome is a heterogeneous group of illnesses. Nevertheless, certain principles should underlie a general approach to treatment planning. All will not necessarily be relevant in the care of any one client but should serve as an initial point of departure. The domains of interest are summarized in Table 2.

Treatment Planning

In general, a collaborative approach to the management of clients with chronic fatigue syndrome is essential. **Internal medicine, which commonly concentrates on infectious disease, is critical to any treatment program that involves the mental health professional.** Consultative assistance from the specialty areas of rheumatology, neurology, and endocrinology may be necessary during the initial investigative stages. Although individual visits with each of the physicians may occur, presentation of the

treatment proposal should ideally involve a meeting of the client with the internist. This format allows for the establishment of a uniform plan of treatment, with a clear outline to the client of the responsibilities and capabilities of the physician(s) and of the client. Furthermore, it fosters the exchange of clinical information and development of a treatment consensus between all involved health professionals. **Such an approach also underscores the lack of current definitive diagnostic testing and the view that chronic fatigue syndrome is, at the present time, a diagnosis of exclusion that does not fall neatly into any discrete clinical domain.** Therefore, if novel symptoms emerge during the course of treatment, careful ongoing medical evaluation and collaborative discussion is necessary to avoid premature diagnostic closure. Finally, such a format establishes a neutral ground to discuss be-

Table 2
AN APPROACH TO CLINICAL MANAGEMENT FOR CHRONIC FATIGUE SYNDROME

Treatment planning

- Collaborative approach
- Joint discussion of treatment plan with client and mental health professionals
- Establishment of a uniform plan of treatment
- Fostering of immediate exchange of relevant clinical data between health professionals
- Ongoing monitoring of treatment progress/problem solving

Laboratory testing

- NO TEST IS AVAILABLE TO CONFIRM THE DIAGNOSIS
- Minimum laboratory testing
 - Complete blood count with differential white blood count
 - Erythrocyte sedimentation rate
 - Chemistry panel (renal and hepatic function testing)
 - Thyroid function testing
- Viral or other infectious serologic tests are only useful to rule out acute infectious states (e.g., Lyme disease, acute cytomegalovirus infection, acute infectious mononucleosis)
- Other testing should be done, when appropriate, only to rule out established diagnostic entities (e.g., brain imaging, endocrine testing, sleep electroencephalography)

Functional assessment: domains of treatment outcome

- Fatigue (duration, severity, longitudinal course)
- Psychological symptoms/syndromes (affective, cognitive)
- Psychosocial adjustment (employment, family, social/leisure activities)
- Sleep pattern assessment
- Pain management (location, severity, presence of tender points, aggravating and ameliorating factors)

havioral symptoms, their meaning for the client, and any possible treatment interventions, whether pharmacotherapeutic or psychotherapeutic.

Laboratory Testing and Functional Assessment

Because of the nonspecific nature of many symptoms of this illness and their suggestion of the involvement of multiple organ systems, the list of appropriate laboratory tests may become quite formidable. Consensus meetings have attempted to provide a minimum battery of screening tests and measures of functional ability during the initial work-up. Substantial clinical information should be obtained to justify further, more expensive or invasive testing.

Education

A complete understanding of the pathophysiology of chronic fatigue syndrome is not available. Unfortunately, in the absence of reliable information, speculative hypotheses ultimately develop the compelling force of established fact. These unproven hypotheses then foster treatment proposals that may have heuristic merit for future research but may, in their present form, be detrimental to the well-being of the client. Therefore, **education of both the client, the treating physicians, and the therapist is essential.** At times, it may involve using the sessions to discuss articles in the medical and lay media, differentiating research hypotheses from clinically useful treatments, and differentiating both from irrational pseudoscience. It is imperative that the treatment context establish a common ground for discussion of such issues.

Prognosis

No descriptive studies have examined the clinical course or specific predictors of long-term outcome of clients with chronic fatigue syndrome. Conclusions about the natural history of the illness are therefore drawn largely from anecdotal experience or inferred from older literature of clinical syndromes that appear identical to what we currently refer to as chronic fatigue syndrome. In most clients, the illness appears to be a self-limited one,

with gradual improvement sparked by intermittent periods of symptomatic exacerbation. Recovery may be anticipated in months to years, rather than in days to weeks. Mortality from chronic fatigue syndrome is assumed to be negligible, but the concurrence of a major depressive episode should introduce concern for the potential risk of suicide.

Conclusion

Chronic fatigue syndrome is most likely a heterogeneous collection of illnesses. A multidisciplinary approach involving mental health professionals in the management of clients with this illness is essential. Elements of a rational treatment program involve a collaborative planning effort, identification of targets for functional outcome assessment, and education.

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Questions Based on this Lesson

33. A client complaining of which one of the following symptoms might be a candidate for chronic fatigue syndrome?
- A. High-grade fever
 - B. Persistent muscular aches
 - C. Gradual onset
 - D. Energy after a long rest
34. Which of the following statements about chronic fatigue syndrome is correct?
- A. Viral infections may contribute to the condition by leading to persistent changes in cellular function long after the initial infection itself has resolved
 - B. It has been conclusively shown that persistent Epstein-Barr virus infection causes chronic fatigue syndrome
 - C. Contact between the therapist and the client's own physician should be kept to a minimum to prevent transference and countertransference problems
 - D. Persistent physical changes after an acute viral infection have been ruled out as possible causes of chronic fatigue syndrome
35. Clients with chronic fatigue syndrome:
- A. Should never take antidepressants, because they can exacerbate the condition even when evidence of depression is also present
 - B. Should always significantly restrict their physical activity until complete improvement occurs
 - C. Should try to ignore the depression they feel, because it always has a completely physical basis
 - D. Should undergo tests to exclude any other clinical conditions or medication effects
36. In the treatment of clients with chronic fatigue syndrome:
- A. The antiviral agent acyclovir has proved spectacularly successful
 - B. All clients should receive a trial with LEFAC, a combination of bovine liver extract, folic acid, and cyanocobalamin (Vitamin B₁₂)
 - C. Intramuscular magnesium sulfate has been reported by Cox and colleagues to produce substantial clinical improvement
 - D. Essential fatty acids should be the primary choice of treatment because initial results of the acids' combined effectiveness have been examined and confirmed by numerous researchers

Directions in Mental Health Counseling

VOLUME 3 • LESSON 10

Research Findings on Short-Term Psychodynamic Therapy Techniques

Jeffrey L. Binder, PhD, ABPP

Dr. Binder is a member of the Core Faculty of the
Georgia School of Professional Psychology, Atlanta, GA.

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Editor's Note

The advent of managed care has resulted in an increase in the practice of short-term psychotherapies. However, knowledge of short-term therapy should not be limited to practitioners affected by managed care. The principles of short-term therapy, a constantly evolving science, can be applied by all mental health professionals in their work with clients.

The author discusses the evolution and nature of short-term therapy, which finds its origin in Sigmund Freud's discovery of the concepts of dynamic hypothesis (the influence of unconscious mental processes on conscious experience and behavior) and transference (the displacement of childhood emotions onto current figures). The *triangle of insight* illustrates the strategy used to link the manifestations of conflict from early events, transference, and current issues.

The first generation of short-term therapists encountered many problems as they applied Freud's philosophy in their techniques. To many, this approach overemphasized the influence of childhood events, often unnecessarily excluding clients from therapy who could not successfully communicate feelings associated with such events.

The new models of short-term treatment are characterized by applications of clinical object relations theory, interpersonal theory, and concepts from cognitive psychology. The "cyclical maladaptive pattern" is used to generate, recognize, and organize psychotherapeutically relevant information. In this second generation of short-term therapy, greater emphasis is placed upon interpretation of here-and-now transference enactments, which tends to be more effective in a wider range of clients. In addition, a clearly defined focus for practical, successful therapy is created and maintained throughout the short-term relationship.

Introduction

In the last few years, enough convincing empirical evidence has surfaced to demonstrate that with some clients, short-term psychodynamic therapies are indeed capable of results once assumed to be achievable only with extended treatment (Koss & Butcher, 1986). Although psychodynamic therapies are commonly associated with substantial length, short-term versions have a long history, dating back to Sigmund Freud's original treatments (Freud, 1895; Jones, 1955).

In fact, the payment and approval structures of many of the new managed health care services necessitate the use—or at least a trial—of short-term psychotherapy. It is the practitioner's responsibility to maintain high-quality care while operating under the severe constraints imposed by the evolving reimbursement systems. This lesson will familiarize the practicing mental health professional with research findings with one type of short-term strategy: psychodynamic therapy.

Historical Background

The principles and procedures of all psychodynamic therapies are based on Freud's two most fundamental discoveries—dynamic hypothesis and transference. **Dynamic hypothesis, the influence on conscious experience and behavior of unconscious mental processes** (Freud, 1895, 1900), **refers to the nature of psychological conflict.** Freud's structural theory provides further specification (Freud, 1923). When a breakthrough into consciousness of unconscious content from the id is imminent, the ego automatically activates a danger signal that is subjectively experienced as anxiety. The danger stems from the superego's prohibitions against the unconscious material. The ego simultaneously activates defenses against this unacceptable content. A compromise is ultimately achieved between unconscious content and censoring forces, as well as the dictates of external reality. This compromise may manifest as personality characteristics or psychological symptoms (Freud, 1926).

Freud's second fundamental principle, **transference, is the primary mode of expression in interpersonal relationships of intrapsychic conflict** (Freud, 1895). Freud originally viewed this phenomenon as a resistance to therapeutic work because it involved reenacting childhood conflicts vis-à-vis the therapist as a substitute for remembering the original experiences. However, he eventually realized that it was also the primary means of identifying, examining, and modifying psychological conflict (Freud, 1909, 1912).

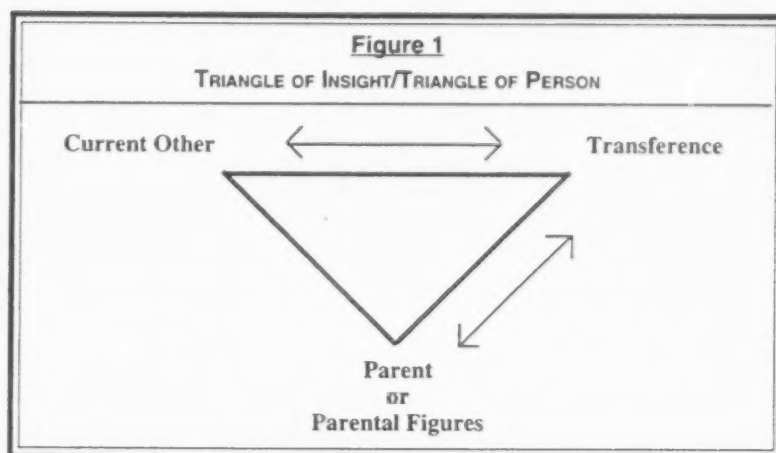
A widely adopted version that retains Freud's original viewpoint defines transference as the repetition of wishes, feelings, fantasies, attitudes, and defenses initially experienced toward parental figures from childhood and now inappropriately and unconsciously displaced onto current figures of emotional significance to the person (Greenson & Wexler, 1969).

Dynamic conflict and transference guided the development of the fundamental strategy of all psychodynamic therapies. For psychological conflict to be resolved, unconscious material must be allowed access to consciousness, where it can be mastered by the adult personality. This process requires removing the defenses against unconscious wishes, feelings, and cognitions. To remove defenses, the imagined dangers associated with unconscious contents first must be identified.

Interpretation is the major therapeutic intervention that facilitates the removal of defenses and clarifies unconscious material (Sandler, Dare, & Holder, 1992). The standard psychoanalytic strategy for interpreting intrapsychic conflict is first to interpret the defenses and their accompanying imagined dangers and then interpret unconscious wishes, feelings, and cognitions.

Psychological conflict is presumed to originate in childhood and, with time, persistently influences many areas of the person's life. **The most immediate expression of conflict occurs in the therapeutic relationship as transference.** The simultaneous identification, of

psychological conflict (expressed as behavior patterns and maladaptive attitudes in the transference), relationships outside therapy, and recollections from the past is called *insight* (Menninger & Holzman, 1973). The client's achievement of insight is assumed to be the catalyst for conflict resolution. The strategy for interpretively linking manifestations of conflict in the three areas of a client's life has been codified as the *triangle of insight* (Menninger, 1958; Menninger & Holzman, 1973) or the *triangle of person* (Malan, 1979) (Figure 1).



Fundamental interrelated therapeutic strategies represented by sequentially interpreting defenses, anxiety, and impulses at the three corners of the triangle of insight have guided all psychodynamic therapies, regardless of modifications introduced in the specific implementation of these strategies.

Modifications to increase the efficiency of psychodynamic treatment were attempted during the first few decades of the 20th century. The aim of uncovering early conflictual childhood memories and their associated affective "charge" was a primary factor in extending psychoanalysis (Freud, 1914, 1937).

Ferenczi and Rank (1925) and, two decades later, Alexander and French (1946) questioned the assumptions that therapeutic change required extensive reconstruction of childhood conflictual experiences and that depth and endurance of therapeutic results were proportionate to prolonged therapeutic exploration. These clinicians believed that all of the therapeutically important past was embodied in the current transference. Therefore, therapeutic change occurs when a client relives chronic conflictual patterns of behavior resulting from the

transference and experiences a different outcome in his or her relationship with the counselor. Alexander and French (1946) termed this occurrence the "corrective emotional experience." To create such an experience, the counselor actively intervenes to promote high emotional engagement in the client and an expression of "core" conflicts in the immediacy of the transference. Furthermore, to avoid prolonged treatments in which clients become overly dependent on the therapy and counselor, these clinicians interrupted treatment, varied the frequency of sessions, and set termination dates. These innovative ideas served as an impetus for the development of contemporary short-term psychodynamic therapies.

The First Generation of Short-Term Dynamic Therapies

In the 1960s, several groups of psychodynamic clinicians—working independently until the 1970s—began to experiment with modifications of therapeutic technique in the context of short-term treatment. These investigators included the Tavistock group in England (Balint, Ornstein, & Balint, 1972; Malan, 1963, 1976), Peter Sifneos (1972, 1979) and James Mann in Boston (Mann, 1973; Mann & Goldman, 1982), and Habib Davanloo (1979) in Montreal.

The short-term treatments developed by these clinicians share five basic features. First, the explicit client selection criteria tend to be rather stringent. For example, suitable clients must be able to describe quickly a circumscribed area of conflict or problem, recall childhood memories clearly connected to the current problem, tolerate high emotional tension, have strong motivation for exploring internal experiences, and engage and disengage from the therapeutic relationship relatively quickly. Second, the counselor is very active in identifying a focused area of work that typically links the current problem with a specific hypothesized childhood conflict with parental figures. Third, the major therapeutic strategy is to link expressions in the transference of the focal conflict with evidence of the same conflict in the client's childhood recollections; this is called the *transference/parent link* (Malan, 1976). Fourth, the counselor actively uses confrontative questions and observations to deal with the client's resistance to emotional engagement in the work. Fifth, the counselor actively limits the length of treatment by carefully selecting clients, avoiding actions that foster client dependency, and, often, setting explicit end points for treatment.

With the exception of James Mann, who appears to have incorporated existential concepts into his treatment model, the first generation of short-term dynamic therapists adhered closely to traditional psychoanalytic principles. They adopted Freud's structural model of intrapsychic conflict as a framework for articulating a focus for therapeutic work. Within this problem focus, in their interpretive interventions, they emphasized one side of the triangle of insight—the link between transference and childhood memories.

This close adherence to traditional psychoanalytic concepts and principles tended to restrict the application of these short-term dynamic therapies. To develop transference/parent links early in therapy, the client must

enter therapy capable of communicating childhood memories that rapidly coalesce into a coherent conflictual theme, which also is identifiable in current relationships and in the transference. This capability is more likely to be possessed by clients with relatively well-organized personality structures and/or good communication skills, regardless of the nature of their symptoms. As a consequence, **many clients who might benefit from short-term therapy are excluded** (e.g., persons with more severe personality disorders or those who, for whatever reasons, do not have ready access to relevant childhood memories).

The primary reliance on the therapeutic strategy of transference/parent interpretive links creates the potential for a serious contradiction in therapeutic aims. On the one hand, **emphasis on the counselor's activity and attention to evidence of a focal conflict in the transference serves to heighten the client's emotional arousal and appreciation of how conflict is currently expressed.** On the other hand, **interpretive links to childhood recollections risk shifting the client's attention from current emotional experiences to relatively intellectualized discussions of distant formative experiences in childhood.**

Another problem is created by defining the therapeutic focus in terms of Freud's highly abstract structural model. The focal problem is conceptualized in terms of unconscious wishes, defenses, and associated unpleasant affects. However, **clients do not experience conflicts in these terms.** People have internal experiences of relationships, with associated views of themselves and others, along with feelings, thoughts, attitudes, and fantasies. Accordingly, counselors talk with clients in these terms. Therefore, the counselor must make a tacit translation of his or her abstract conception of the client's conflict into language the client understands. Because there are no guidelines for making this translation, the typical result is a loss of clarity and specificity. Thus,

Malan (1976) described the process by which a counselor defines a conflict focus as highly intuitive: it represents a gradual "crystallization" in the counselor's mind of an appropriate area of work. There are no explicit guidelines for teaching this process to counselors. Furthermore, **there is a lack of reliability among counselors in formulating a problem focus for a given client.** If each counselor must wait for a focus to crystallize in his or her mind, there is no way to encourage similarity in foci that eventually materializes for counselors treating the same client.

The Second Generation of Short-Term Dynamic Therapies

In the past few decades, new models of short-term treatment have appeared, which in varying degrees incorporate concepts and principles from interpersonal theory and cognitive psychology into a contemporary psychodynamic theoretical framework (Crits-Christoph & Barber, 1991; Horowitz, 1976; Luborsky, 1984; Strupp & Binder, 1984). The aim of such theoretical integrations is to **maximize the use of concepts that are clearly explicable and closely tied to clinical experience.** Teaching the models is therefore more effective, and the therapeutic strategies and tactics distinguishing each model are more amenable to empirical testing.

These new models of short-term treatment have resulted in advances in procedures for selecting clients who are likely to benefit from short-term dynamic therapy, in guidelines for clearly specifying a problem focus, and in the use of technical procedures for increasing the likelihood of a beneficial therapeutic outcome.

CLIENT SELECTION:

Selection criteria for clients deemed suitable for short-term dynamic therapy have been rather stringent (Crits-Christoph & Barber, 1991; Davanloo, 1979; Malan, 1976;

Sifneos, 1979). The original criteria were derived from dimensions of personality traditionally considered necessary for a client to benefit from psychoanalysis, and include such characteristics as the capacity to discuss feelings, basic trust, and motivation for self-knowledge. A prospective candidate for short-term therapy must meet additional criteria, including a circumscribed problem and the capacity to engage and disengage rapidly from treatment.

A problem with these criteria is the lack of evidence that counselors can use them in practice to predict successful outcome with short-term dynamic therapy (Binder, Henry, & Strupp, 1987). **Attempts to quantify various selection criteria (e.g., global adjustment, health-sickness, and expectancies about therapy) have yielded modest associations with outcome** (Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988). Lewis Wolberg (1980) foreshadowed these findings when, more than a decade ago, he advised that *everyone* should receive brief therapy, at the end of which a decision to continue could be made. An important implication in this recommendation is that in any given treatment, **the quality of the therapeutic process (e.g., the therapeutic alliance) is a better predictor of outcome than pretreatment client variables** (Luborsky et al., 1988).

Emphasizing pretreatment client variables as selection criteria assumes that the client will respond similarly to any therapist using a particular treatment model. However, it appears that **treatment outcome is the result of an interaction between the client's characteristics, the counselor's style of relating, and the technical strategies employed** (Luborsky et al., 1988; Piper, Azim, Joyce, McCallum, Nixon, & Segal, 1991). In support of this notion, recent empirical research has suggested that **the client's measured characteristic "quality of object relating" is predictive of the type of therapeutic strategy that will prove successful.** Clients with numerous problems in relating respond best to short-term dynamic therapy in which interventions emphasize help with cur-

rent problems and maintain the client's experience of being supported by the counselor. Clients with a relatively good capacity for relating respond well to a prudent strategy of interpreting transference, including transference/parent links (Piper, Azim, Joyce, & McCallum, 1991).

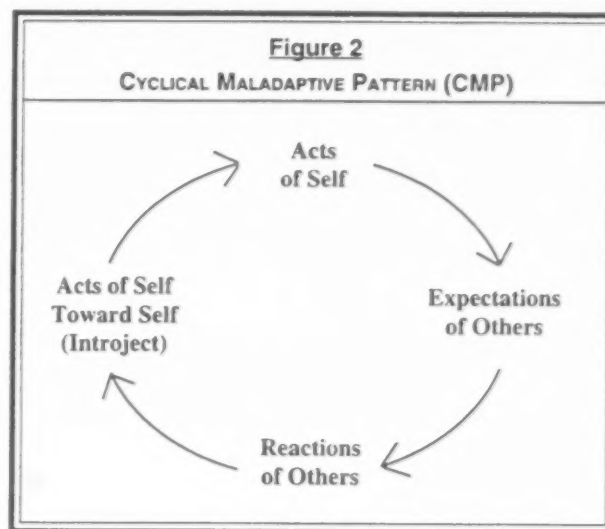
When using short-term dynamic therapy, allow a great deal of latitude in the criteria used to select clients, emphasizing evidence for the client's characteristic capacity for interpersonal relating (Binder & Strupp, 1991); also, **employ selection criteria to guide therapeutic strategy rather than to include or exclude clients from this form of treatment.**

TREATMENT FOCUS:

The reliance on classic psychoanalytic metapsychological theory does not provide clear-cut guidelines for formulating a therapeutic focus. The second generation short-term dynamic therapies are characterized by applications of clinical object relations theory, interpersonal theory, and concepts from cognitive psychology (Horowitz, 1988; Strupp & Binder, 1984; Weiss & Sampson, 1986). These contemporary treatment models view the personality as a hierarchical organization of relatively enduring internal transactions, with specific characteristics attributed to the self and to internal representations of significant others. Specific intentions, fantasies, attitudes, and feelings are associated with a given internal transaction model. Intrapsychic conflict is conceptualized in terms of opposing "wished for" and "dreaded" internal transactions (Horowitz, 1991). However, **emphasis is placed on external expression in interpersonal relationships of internal transactions.**

A good example of the principles and procedures guiding the formulation of a focus in these contemporary models is the *cyclical maladaptive pattern* (CMP) method associated with Time-Limited Dynamic Psycho-

therapy (Binder & Strupp, 1991; Strupp & Binder, 1984). **Problems are conceptualized in a format that avoids abstract and vague formulations.** A client's presenting problems are translated into interpersonal terms and organized into a format called the cyclical maladaptive pattern (Figure 2). **The CMP is used as a heuristic, helping counselors to generate, recognize, and organize psychotherapeutically relevant information. It is not an absolute or final formulation of the problem; rather, it is used throughout the course of treatment as a tool for keeping the counselor focused on a salient-conflict theme.**



The CMP describes a central or salient pattern of interpersonal roles that includes the role in which the client unconsciously casts himself or herself; the complementary roles in which he or she casts others; and the maladaptive interaction sequences, self-defeating expectations, negative self-appraisals, and unpleasant affects that result. (When enacted with the counselor, this pattern is considered to be transference.) The CMP specifies four categories of information: (1) acts

of self; (2) expectations of others' reactions; (3) acts of others towards self; and (4) actions of self toward self (introject).

Acts of self include both private and public actions, such as feelings and behavior, which vary in the degree to which they are accessible to awareness.

Expectations of others' reactions are imagined reactions of others to one's own actions. Such expectations may be conscious, preconscious, or unconscious.

Acts of others toward self are observed acts of others viewed as occurring in specific relation to the acts of self. Often, one unwittingly acts in ways that evoke feared, but anticipated, responses (the principle of complementarity). Under the influence of a maladaptive pattern, one also typically tends to misconstrue the interpersonal meanings of others' actions in a way that confirms one's wished for or feared expectations.

Actions of self towards self refers to how one treats oneself (e.g., self-controlling, self-punishing, or self-nurturing). These actions should be articulated in specific relation to the other elements of the format. How a person treats himself or herself tends to be a reflection of how he or she perceives treatment by others.

The cyclical maladaptive pattern ideally should encompass a pattern of interpersonal transactions that is both historically significant and a source of current difficulty. However, a cyclical maladaptive pattern is constructed based upon information gathered from observations of the client's behavior elicited in the interview and from reports of current relationships. As information becomes available regarding relationships dating back to childhood, it provides a context in which ambiguous meanings of present events may be understood more easily. However, this historical information is not essential for formulating a cyclical maladaptive pattern.

Because formulation models like the CMP explicitly define the categories for organizing clinical infor-

mation and require relatively low inference from clinical data, they are amenable to empirical quantification. Methods for reliably identifying a therapeutic focus have been developed for the "core conflict relationship theme" by Lester Luborsky and his research team (Luborsky & Crits-Christoph, 1990) and for the "plan diagnosis" by the Mount Zion research team (Silberschatz, Curtis, & Nathans, 1989). Plans currently are under way to operationalize the CMP. Future work by psychotherapy researchers on methods for precisely formulating dynamic foci may have further applications for the practitioner. It is crucial for dynamic therapists to take advantage of whatever tools become available to aid in identifying and tracking a meaningful therapeutic focus.

TECHNIQUE:

The fundamental technical strategy of the first generation of short-term dynamic therapies relies on genetic transference interpretations or transference/parent links (Davanloo, 1979; Malan, 1976; Sifneos, 1979). Malan explicitly asserted that the frequency of transference/parent link interpretations was correlated positively with successful outcome.

The second-generation therapies place greater emphasis upon interpretation of here-and-now transference enactments, which is assumed to be effective in a wider range of clients and minimizes the risk of transient intellectualized insights.

Interpretations of transference/parent links are used sparingly, and the rule of thumb is to use them *after* the client demonstrates appreciation of the current existence of a maladaptive interpersonal pattern (Luborsky, 1984; Strupp & Binder, 1984). Until recently, the therapeutic efficacy of interpretations, particularly of the transference type, has been accepted on the basis of clinical experience, which has an element of faith attached to it.

Recent advances in research methodology have

resulted in various methods of empirically measuring and assessing the impact of psychodynamic techniques. Converging evidence indicates that interpretations of any kind are not predictive of successful outcome (Crits-Christoph, Cooper, & Luborsky, 1988; Henry, Strupp, Schacht, Binder, & Butler, 1992; McCullough, Winston, Farber, et al., 1991; Piper, Debbane, Bienvenu, de Carufel, & Garant, 1986; Silberschatz, Fretter, & Curtis, 1986). These findings for short-term dynamic therapy are consistent with the more general finding that technical adherence to the prescribed interventions of a particular therapeutic model is not predictive of therapeutic outcome (Beckham, 1990; Beutler, 1991). One important reason for this is that using prescribed interventions is only one skill within the poorly understood array of skills that comprise therapeutic competence (Binder, Strupp, & Rock, 1992; Schaffer, 1982).

A technical skill shown to correlate with successful outcome is the counselor's consistent ability to make the content of interventions relevant to the agreed-upon therapeutic focus (Crits-Christoph et al., 1988; Silberschatz et al., 1986). Therefore, a precise initial formulation of the focus will facilitate attempts to offer consistently relevant interventions.

Another technical skill, or set of skills, involves maintaining a positive therapeutic alliance. Empirical evidence indicates that even a very subtle "negative process" can have a profoundly destructive impact upon treatment (Henry, Schacht, & Strupp, 1986, 1990). Binder

and Strupp (1991) have warned that the pervasiveness of negative transference/countertransference processes and the difficulty counselors encounter with these processes have been underestimated. The adage "anything powerful enough to help can also harm" evidently is true for interpretations, particularly of the transference variety. The implication is clear: **interpretations must be used judiciously and their impact monitored closely** (Piper, Azim, Joyce, & McCallum, 1991; Piper, Joyce, McCallum, & Azim, 1993).

Conclusion

Current formulations of short-term dynamic therapies indicate that:

- Greater latitude can be used in selecting clients
- It is essential to formulate and address consistently a precise and meaningful focus
- Technical flexibility is essential
- Interpretations should be used judiciously

Further research may demonstrate that skillfully delivered transference interpretations have a strong beneficial effect on the therapeutic process and its outcome. Such a finding would reinforce the notion that if interpretations are powerful "medicine," then they must be used with skill and care. In the meantime, convincing evidence demonstrates that short-term dynamic therapies produce significant benefits (Crits-Christoph, 1992; Crits-Christoph & Barber, 1991).

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Questions Based on this Lesson

37. The author describes the transference/parent strategy as linking expressions of the client's main conflict with evidence of the same conflict in the client's childhood. Which of the following is not cited as a drawback of this strategy?
- A. The focus has been defined in terms of Freud's highly abstract structural model, which does not generally reflect client's experiences of other conflicts
 - B. Many clients have difficulty recalling, organizing, and articulating childhood memories
 - C. Events from childhood are usually irrelevant to the client's current context
 - D. Counselors often find it difficult to translate clearly their perception of the conflict into language the client understands
38. The cyclical maladaptive pattern:
- A. Describes a pattern of interpersonal roles that helps the therapist organize relevant information
 - B. Represents an absolute, final formulation of a client's problems
 - C. Prevents the counselor from focusing on a salient-conflict theme
 - D. Conceptualizes problems in a vague and abstract form
39. Which of the following statements is true?
- A. The *triangle of insight* was used by Freud to examine the interactions among the three parts of the subconscious
 - B. Second generation short-term therapies use information from childhood to aid in understanding present events.
 - C. The empirical quantification of first generation short-term therapies is completely responsible for the advances of second generation short-term therapies
 - D. *Expectations of others' reactions* are all located in the subconscious preceding the employment of the cyclical maladaptive pattern
40. Which of the following is not cited by the author as correlating with successful short-term therapy?
- A. The use of nonconfrontative questions and observations to deal with client's resistance
 - B. Faithful adherence to clear-cut guidelines
 - C. A positive therapeutic alliance
 - D. The therapist's ability to make the content of interventions relevant to the therapeutic focus

Directions in Mental Health Counseling

VOLUME 3 • LESSON 11

Geriatric Alcoholism: Identification and Elder-Specific Treatment

Jayne Reinhardt, MPH, and George Fulop, MD, MCSM

Ms. Reinhardt is Public Health Educator for the
San Diego County [CA] Alcohol and Drug Services.

Dr. Fulop is Assistant Professor, Departments of Community Medicine,
Geriatrics, and Psychiatry at The Mount Sinai School of Medicine, New York, NY.

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Editor's Note

Alcoholism is defined as the repetitive use of alcohol that causes physical, psychological, or social harm to the drinker and/or to others. The drinker typically denies the problem or refuses to deal effectively with it. Ten to fifteen percent of the elderly suffer from the disease.

Three distinct groups of elderly alcoholics are commonly described. The early-onset alcoholic begins to drink before age 40 and continues to drink into old age. A family history of alcoholism is common, and these persons suffer from other medical problems. Clients with late-onset alcoholism show no evidence of earlier drinking problems. For them, drinking is often a direct response to life stressors such as social isolation, limited family supports, physical and cognitive impairment, and financial limitations. Intermittent alcoholics demonstrate occasional episodes of heavy drinking earlier in life, alternating with periods of sobriety. Again, late life stressors are probably major contributors.

In this lesson, the authors review the general physical, psychological, and social impacts of drinking and point out some of the characteristics specific to older clients. Furthermore, they note that the elderly are more sensitive to alcohol; they often have higher rates of concurrent physical and psychological disorders, including depression and suicide. Because they often take prescription drugs, combining these with alcohol can induce detrimental side effects.

Alcoholism is commonly misdiagnosed or overlooked in the elderly, so all professionals should be especially alert to its possibility. The authors set forth principles of successful treatment approaches for elderly alcoholics; these not only encourage sobriety, but must also attend to such daily concerns as loneliness, loss of independence, and declining health. Behavioral therapy models have been effectively used, and outreach strategies are important as well. Unconditionally offered support and ways to renew hope and self-esteem are critical recovery strategies.

Introduction

Although alcohol abuse and dependence decline with increasing age, they continue to pose a serious public health problem and a challenge to the treating mental health specialist. Recognizing significant age-related characteristics of the elderly alcoholic can help identify elderly problem drinkers, implement elder-specific treatment plans, and help elderly alcoholics avoid the serious medical and social consequences of alcoholism. This lesson describes the number and types of elderly alcoholics and the diverse treatment programs available today.

Epidemiology of Elderly Alcoholism

It is estimated that **10%–15% of the elderly are alcoholics** (Robertson, 1992). As in younger alcoholic populations, **men outnumber women**. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimates that approximately **10% of elderly men and 2% of elderly women are heavy or problem drinkers** (Williams, 1984).

Problem drinking has been defined as the “repetitive use of [the] beverage alcohol causing physical, psychological or social harm to the drinker or to others” (Plaut, 1970). Regier and colleagues (1988) cite a 0.9% overall one-month prevalence rate with 1.8% men and 0.3% women alcoholics among community-dwelling elderly. The DSM-III-R draws a distinction between “alcohol abuse” and “alcohol dependence” (American Psychiatric Association, 1987). **Despite knowledge that alcohol causes social, occupational, psychological, and medical problems, alcohol abusers continue to drink excessively. Alcohol-dependent people, however, have impaired control over their drinking behaviors. The dependence syndrome includes physiologic symptoms of tolerance and withdrawal. The term “alcoholic” will be used in this lesson to describe those people who have problems with alcohol, abuse alcohol, or are alcohol dependent.**

Clinical Settings

Researchers agree that active alcoholism in all age groups tends to be found more frequently in clinical settings rather than in community sites (Atkinson, 1984). Brody (1982) reports that among the elderly population, **10%–15% of all who seek medical attention for any reason have alcohol-related problems**. In their random sample of 84 patients from a general medical geriatric outpatient clinic, Fulop and Reinhardt (unpublished) found that 4.8% of geriatric outpatients scored in the alcoholism range (>5) on the 25-question Michigan Alcohol Screening Test (MAST). After analyzing the results of a survey designed to determine the characteristics of elderly alcoholics, as well as physicians' practice patterns for alcoholism in all major patient-care departments at the Johns Hopkins Hospital in Baltimore, Curtis and colleagues (1989) documented that **15%–26% of geriatric medical inpatients have alcohol-related problems**. In a report by the San Diego Association of Governments (1991), it is stated that **one fourth of seniors in psychiatric wards are alcoholic**.

Age of Onset

Three distinct groups of elderly alcoholics with different ages of onset have been described: early-onset, late-onset, and intermittent (Atkinson, 1984; Bahr, 1969; Gomberg, 1982; Pruzinsky, 1987).

EARLY-ONSET ELDERLY ALCOHOLISM:

The early-onset elderly problem drinker **began drinking before age 40** and, having survived the obstacles of alcohol abuse and dependence, continues drinking into old age. Some studies have indicated that these individuals are **more likely to demonstrate life-long addictive patterns and have weak affiliations with family, employment, or voluntary agencies** (Bahr, 1969). Demographic characteristics show that **family alcoholism was more common among early-onset drinkers** than among people who began drinking after the age of 60 (Atkinson, Turner, Kofoed, & Tolson, 1985).

In reviewing the records of 216 elderly alcoholics who were admitted to the Alcoholism and Drug Dependence Unit (ADDU) at the Mayo Clinic in Rochester, MN, between 1972 and 1983, Morse (1988) also found that the **early-onset drinkers exhibited more medical problems than the other two groups of elderly alcoholics** (late-onset and intermittent). They also found that early-onset alcoholics reported having a greater number of diagnoses that included **cirrhosis of the liver, peripheral neuropathy, and cerebellum degeneration**.

LATE-ONSET ELDERLY ALCOHOLISM:

Late-onset elderly problem drinkers begin abusing alcohol in later life, exhibiting no evidence of previous drinking problems. These excessive drinkers are more likely to have enjoyed **high occupational status** throughout most of their adult lives (Bahr, 1969), and report **fewer family histories of alcoholism** (Atkinson et al., 1985). Atkinson (1984) found that **late-onset problem drinkers exhibited greater psychological stability and higher socioeconomic status** than did early-onset drinkers.

The etiology of late-onset alcoholism remains controversial. Many researchers (Atkinson, 1988; Finlayson, Hurt, Davis, & Morse, 1988; Finney & Moos, 1984; Hurt, Finlayson, Morse, & Davis, 1988; Olsen-Noll & Bosworth, 1989) hypothesize that **late-onset elderly alcoholism is a direct response to life stressors**. These stressors include some of the social problems that are often present for all older people such as **social isolation, limited family supports, and physical and cognitive impairment**—as well as **financial limitations** that may put restrictions on their activities (Weins, Menustik, Miller, & Schmitz, 1982–1983).

Finney and Moos (1984) defined life stress as a **"component of one or more of several combinations of factors that may trigger or perpetuate drinking problems."** They critically examined several studies that empirically associated life stressors with the late-onset of problem drinking in the elderly as well as with the triggering of problem drinking in the elderly intermittent group. They concluded that much of the evidence acquired from

these studies is consistent with the stress theory. However, because **"the pervasiveness of the stress hypothesis in the alcoholism and gerontology fields derives more from its intuitive appeal than from empirical research,"** they believe that **stress can only be considered one component** among a combination of factors attributing to the late onset of excessive drinking in older people.

Finlayson and colleagues (1988) reviewed the medical records of the 216 elderly patients who had been treated for alcoholism between 1972 and 1983 at the ADDU. They found that **various life events were associated with or exacerbated the early and late onset of problem drinking** among 211 ADDU elderly patients. Stressors were attributed to the onset of their exacerbated drinking in 81% of the late-onset drinkers.

INTERMITTENT ELDERLY ALCOHOLICS:

A third group, **intermittent alcoholics**, is also present. These individuals have experienced **occasional episodes of heavy or problem drinking earlier in their lives that alternated with periods of sobriety**. Similar to the case of late-onset elderly alcoholism, **relapse among the intermittent elderly problem drinker may also be considered a response to the stressors of growing older and losing various motivating factors for remaining sober**; i.e., job, spouse, good health (Gomberg, 1982; Olsen-Noll & Bosworth, 1989; Pruzinsky, 1987).

Effects of Problem Drinking on the Elderly

In all age groups, the effects of alcohol can be quite severe. Alcohol **slows brain activity and impairs mental alertness and judgment**. In addition, alcohol use **alters physical coordination and reaction time**, which increases the risks of falling and having accidents. Over time, excessive drinking can cause **permanent brain and central nervous system (CNS) damage**, as well as **impair the liver, heart, kidneys, and stomach** (United States Department of Health and Human Services, National Institute on Aging, 1983).

Although problems associated with occupational functioning and interacting with friends and neighbors, as well as those related to the police, appear less often for elderly individuals, Hinrichsen (1984) reports that **negative physiological and societal implications are still quite pertinent; even limited use of alcohol among elderly persons may cause more significant problems than among individuals under the age of 60.**

Alcoholism also creates other costs, not only to the alcoholic and significant others, but to innocent bystanders, such as car accident victims. Two million alcohol-related car crashes occur each year at a total cost of \$10-\$15 billion (Brody, 1988).

Elderly alcoholic clients present special problems that are not seen in younger populations. **Older people's reaction to alcohol is much stronger than in their younger counterparts.** Because lean body mass decreases by about 10% from age 20 to age 70 and the body water component accounts for a smaller percentage of total mass, the amount of alcohol consumed is distributed to a smaller volume, resulting in a higher blood alcohol concentration (Olsen-Noll & Bosworth, 1988). Therefore, using quantity and frequency as criteria to diagnose elderly problem drinkers could be very difficult and quite inaccurate. Moreover, the rates of concurrent medical disorders, death, depression, and suicide are higher among geriatric problem drinkers than among nondrinkers of the same age group.

PHYSIOLOGIC COMPLICATIONS:

Hurt and coinvestigators (1988) found that alcoholics had a higher frequency of psoriasis and peptic ulcer disease than did the general elderly population. Morse (1988) also reported that organic brain syndromes were the most "important psychiatric problems" of the alcoholic group.

Compared with their younger counterparts, elderly alcoholics are more prone to liver disease, cancers and other chronic illnesses, and organ damage (Grispoon, 1986). Excessive drinking can also double many com-

mon age-related physical ailments, such as occult cardiovascular disease, osteoporosis, hypoglycemia (an abnormally low concentration of glucose in the blood), hyperuricemia (enhanced blood concentrations of uric acid), and hypertriglyceridemia (elevated triglyceride concentrations in the blood) (Atkinson, 1984).

Studying alcohol use among a group of semi-independently living nonagenarian (>90 years old) men and a group of 65-75-year-old men of similar demographic characteristics, Jensen and Bellecci (1987) found significant evidence that suggested **alcohol use was related to the frequency of major medical illnesses among both groups.** They reported that the heavier drinkers tended to have higher frequencies of major illnesses when compared with those who reported rarely or never drinking (3.8 vs. 2.4). After studying 200 patients with liver disease, Potter and James (1987) reported that 28% of alcohol liver disease in persons 60 years or older was found to be related to alcoholism, with mortality rates of 34% and 53% at 1- and 3-year followups. Comparing laboratory test results of the elderly ADDU patients admitted during 1972-1983 with those of a group of younger ADDU (mean age 44.3 years) patients admitted during 1978-1979, Hurt and colleagues (1988) found that out of 10 laboratory tests reviewed, results from five of these tests were more often abnormal in the elderly alcoholic group.

Medications and Alcohol Interactions

Although the elderly constitute about 10%-12% of the American population, they take more than 30% of all prescription drugs and 40% of all over-the-counter (OTC) medications. Atkinson (1984) found that 80% of elderly OTC drug users simultaneously ingest alcohol, prescribed medications, or a combination of the two. According to the Food and Drug Administration, 50% of all drugs consumed by older adults can interact with alcohol (Katz, 1991). Because older adults experience increased sensitivity to all drugs that are central nervous system depressants, combining alcohol (a CNS depressant) with any one of these drugs can be fatal to the older adult (Katz, 1991). In addition,

using alcohol with commonly prescribed drugs (e.g., CNS depressants, analgesics, cardiovasculars, antidiabetics, and anticoagulants) can significantly alter motor and sensory functions, and negatively affect vitamin absorption (McGlone, 1983).

PSYCHOLOGICAL COMPLICATIONS:

In a group of 61 elderly patients treated for alcoholism, Pottenger and colleagues (1978) found that 59% were clinically depressed. Bienenfeld (1987) reports that depression is uniformly present in alcoholics, especially because alcohol has a direct depressant effect; also, society tends to isolate drinkers, leading them into a spiral of loneliness. Dupree and coworkers (1984) reported that a large percentage of the clients participating in a 24-day alcoholism pilot treatment program drank alone at home and mostly reported being depressed or lonely just prior to taking their first daily drink.

Alcohol had been considered in 35% of all suicide cases (West, Maxwell, Noble, & Solomon, 1984). Osgood (1987) reports that excessive alcohol use and depression have been associated positively with elderly suicide rates. Compared with other age groups, the elderly population has the highest rate of completed suicides. Overall, this group accounts for 17%–25% of all suicides (Osgood, 1985).

Identification of Elderly Alcoholism

POOR DETECTION:

In a report by West and colleagues (1984), Dr. David H. Solomon notes that defining alcoholism in the elderly population is quite difficult because criteria that are normally used to detect alcoholism in other age groups (such as driving violations or accidents, public disruptions, or absences from work) may not be applicable to the elderly. There is also a low index of suspicion, and lifestyle difficulties that can result from excessive alcohol use in younger populations are often absent in the elderly,

resulting in fewer problems with the police and the legal system. In addition, Bienenfeld (1987) points out that many elderly alcoholics are widowed, generally retired, and often do not drive. Therefore, they seldom attract attention because of trouble with work or marriage, thereby lowering the reported prevalence rates of elderly alcoholics.

PROBLEMS OF DENIAL:

The denial of the alcoholic and significant others only adds to the major problems of underdiagnosis of, and lack of proper treatment for, elderly alcoholic clients. Bienenfeld (1987) notes that the most difficult aspect of detecting and treating alcoholism in persons of any age is overcoming the denial that is commonly associated with this disease. He explains that family members, close acquaintances, or even public agency and state institution personnel often act as enablers for the elderly alcoholic by providing a refuge for this person.

It is quite possible that an employer may wish to carry along an older, dysfunctional employee as a token of appreciation for past service. Guilt feelings may also prevent the spouse of an elderly alcoholic from confronting his or her mate about the problem (Bienenfeld, 1987).

SCREENING INSTRUMENTS:

The mental health professional can increase the detection of alcohol problems by asking a few pertinent questions or administering a brief screening questionnaire. One concise screening instrument is the four-question CAGE. Ewing (1984) notes that the questionnaire asks participants about:

- Their feelings about the need to Cut down on their drinking
- Whether they have been Annoyed by other people's criticism of their drinking
- Their bad or Guilty feelings about their drinking
- If they have ever had an Eye opener (a drink first thing in the morning) to "steady their nerves"

Another screening instrument, the Brief MAST, is a 10-item version of the more detailed 25-question original MAST and seems to be well tolerated by the elderly.

Treatment and Prevention Strategies

Once identified, the elderly alcoholic responds well to treatment (Williams, 1983; Zimberg, 1978). Treatment options for the elderly similar to those for young alcoholics (e.g., psychotherapy, detoxification and rehabilitation, disulfiram [Antabuse], Alcoholics Anonymous [AA], etc.) will not be discussed here because of general awareness of these options. However, a number of age-specific model programs have been identified. In general, treatment may be in mixed-age or elder-specific groups. Some have argued that treatment intervention for elderly alcoholics can be most effective when delivered through facilities that specifically treat elderly clients rather than through general psychiatric or medical institutions. These may include senior citizen centers, outpatient geriatric medical or psychiatric facilities, nursing homes, or geriatric home care programs (Zimberg, 1978).

Although some programs have been developed specifically to meet the demands of the elderly alcoholic (Dunlop, Skorney, & Hamilton, 1982; Dupree et al., 1984; Glasscock, 1979; Kofoed, Tolson, Atkinson, Toth, & Turner, 1987), the need for these programs continues to outweigh the number of those developed and implemented.

Model Geriatric Alcohol Treatment Programs and Strategies

Olsen-Noll and Bosworth (1989) explain that treatment for the elderly problem drinker must focus on such daily concerns as loneliness, loss of independence, and declining health. Zimberg (1978) suggests that the treatment approach for elderly alcoholics should place

emphasis on compensating for various age-related losses and stresses that are not applicable to younger populations.

Several strategies have been delineated in the treatment of geriatric alcoholism. These modalities include, but are not limited to, inpatient and outpatient settings—including those that are elder-specific, non-elder-specific, or mixed aged, as well as those implementing the disease, behavioral, and self-management models of treatment—outreach strategies, peer support, and family involvement.

Inpatient Mixed-Age Treatment

DISEASE MODEL:

Some inpatient programs incorporate the disease model of alcoholism into their treatment strategies. Hurt and colleagues (1988) conducted a retrospective epidemiologic study of the 216 elderly patients of the ADDU. Their goal was to determine, among other things, the demographics of a group of elderly alcoholics, and to analyze differences between early- and late-onset alcoholics. The ADDU was already in place when the researchers retrospectively examined the medical records of the 216 participants. (The ADDU itself is not an age-specific treatment center since it treats both older [age greater than 60] and younger patients.)

The ADDU's treatment approach is based on the disease concept of addiction. The treatment program integrates "multidisciplinary-staffed modalities for treatment of addictions with psychiatric and specialty-oriented medical care." Upon admittance to the 28-day program (28 days in the first 2 years of the study, but those who entered in or after Year 2 stayed only 21 days), each patient underwent an initial diagnostic assessment, which included a medical and psychological examination (Hurt et al., 1988).

Intervention strategies included education through films and lectures (Finlayson et al., 1988), individual and group psychotherapy, addiction counseling, physi-

cal exercise, family participation, an introduction to AA (Hurt et al., 1988), and aftercare planning (Finlayson et al., 1988).

Although the researchers primarily focused on the participants' medical and social information, they assessed the elderly alcoholic's quality of life through demographic data, medical characteristics, laboratory test results, treatment outcomes, and comparisons of early- and late-onset alcoholism (Hurt et al., 1988). They found that the frequency of serious medical disorders for this group was higher than would be expected for the overall population of the same age. They concluded that more intensive treatment might be required for some elderly alcoholics because of the high frequency of major medical and psychological problems among this population (Hurt et al., 1988).

Other investigators such as Zimberg (1978) and Thomas-Knight (1978) have expressed the view that therapy directed at the social, psychological, and physical stresses associated with aging would be quite sufficient for treating elderly alcoholics. However, Hurt and colleagues (1988) dispute the effectiveness of simply socializing elderly alcoholics; they claim that this group must receive comprehensive treatment comparable to, if not exceeding, treatment provided for younger alcoholics.

BEHAVIORAL MODEL:

An inpatient alcoholism treatment program was instituted at the Veterans Administration Center in Jackson, MS (Miller, Stanford, & Hemphill, 1974). After examining the results of a survey of hospital admissions from the medical and psychiatric wards at the Center, researchers found that 40% of entering patients demonstrated a significant alcohol problem. To combat this situation, Miller and colleagues (1974) explain that emphasis was placed on changing the individual's daily life functions (attitudes, skills, and behaviors).

Within this framework, alcoholism is viewed as a socially acquired habitual behavior pattern that en-

ables the alcoholic to avoid or escape from unpleasant or anxiety-producing situations, gain attention from friends and family, and avoid withdrawal symptoms associated with the termination of drinking (Miller et al., 1974).

One strategy of this threefold treatment approach is to change the problem drinker's attitude by decreasing the immediate reinforcing properties of alcohol through electrical, chemical, or verbal aversion therapy techniques (Miller et al., 1974). Having identified several of the behavioral and nonbehavioral factors associated with persistent drinking, it is possible to develop a behavioral inventory by identifying the behaviors that are incompatible with excessive drinking and ultimately to teach the alcoholic new skills to cope with life (Miller et al., 1974).

Another component of this approach encourages the elderly alcoholic to participate in a token-economy system, which offers rewards through privileges. The intent of this reward system is to reinforce positive, therapeutically goal-oriented behaviors that are incompatible with excessive drinking (Miller et al., 1974). Miller and colleagues (1974) explain that the Mississippi Program offers social and vocational counseling based on the notion that the individual will remain only temporarily sober unless he or she directly enters into a satisfying and health-promoting employment and social environment. However, because many elderly alcoholics are retired, it would be necessary to provide counseling that would address the specific needs of this target population.

Similar to other alcohol treatment programs, the Veteran's Administration Mississippi program includes family treatment with a goal of producing change that will lead to growth among family members, as well as promote healthy marital relationships for married clients (Miller et al., 1974).

OUTREACH STRATEGIES:

The Senior Alcoholism Services (SAS) of Vancouver,

WA, is an example of another age-specific residential alcohol treatment program that implements a different approach to treating the elderly alcoholic. Created as a result of a needs assessment of the elderly population in Clark County, WA, the project's primary goal is to help older alcoholics stop drinking and begin living through sobriety by **turning their problems into new opportunities** (Dunlop et al., 1982).

As previously mentioned, Bienenfeld (1987) explains that **denial** is a primary characteristic of alcoholism. **Outreach alcoholism counselors must break through this denial.** In the SAS program, the counselors' major involvement with the clients has been in the **motivational and the aftercare treatment phases.** Rather than waiting for clients to arrive at the SAS office voluntarily, counselors make themselves available to hospital patients and nursing home clients who have been identified as having alcohol-related problems. Also, counselors visit potential clients' homes to encourage them to participate in the program (Dunlop et al., 1982).

Clients who have been motivated to participate in the program are generally **admitted for 21–30 days of intensive treatment which includes individual counseling, family and couples therapy, self-esteem building programs, and other activities that can serve as alternatives to excessive drinking** (Williams, 1983). Moreover, by assisting the SAS clients in filling out public assistance forms for housing and health care, social workers demonstrate that the clients' needs will be met regardless of the financial costs (Williams, 1983).

PEER SUPPORT:

Dunlop and colleagues (1982) also found that, in the SAS Project, **sensitive peer support groups consisting of other elderly recovering alcoholics serve as reinforcing factors to recovery.** They reported that **geriatric problem drinkers respond just as positively to group therapy as do younger populations if the specific concerns of the elderly are addressed, including estrangement from children, loss of driving ability, and death of a spouse.**

FAMILY INVOLVEMENT:

In his experience treating patients in a geriatric psychiatric program and consulting in medical home care programs and nursing homes, Zimberg (1971) reports that along with group therapy, socialization, and medical care, **family casework is a preferred strategy in treating alcoholism among the elderly.** Indeed, family involvement is a large component of the SAS program. Many family members enabled their elderly alcoholic relatives to continue drinking excessively because they felt that they were protecting them by allowing them to "enjoy one of the final pleasures." Families are encouraged to attend meetings to acquire alcoholism information and continued emotional support (Williams, 1983).

Elder-Specific Outpatient Treatment

For other elderly alcoholic persons, **outpatient treatment programs offer the most beneficial treatment.** At the time of entry into a special outpatient alcohol treatment program, 36 active elderly alcoholics were assessed on selected demographic, psychological, and alcohol-related variables. In comparing the treatment outcomes of 14 early-onset problem drinkers with 22 late-onset problem drinkers from this group, Atkinson and colleagues (1985) concluded that **both of these elderly groups are much more compliant to treatment than are younger alcoholics.**

BEHAVIORAL AND SELF-MANAGEMENT STRATEGIES:

Similar to the Mississippi Veterans Administration inpatient alcoholism treatment program (Miller et al., 1974), the Gerontology Alcohol Project (GAP) described by Dupree and colleagues (1984) applied **behavioral and self-management strategies designed specifically for elderly alcoholics.** An elder-specific, 24-day pilot day treatment alcoholism program located in Florida, the GAP was developed to investigate the location, description, and treatment of late-onset alcoholics. Po-

tential participants were asked to assess five life areas in which the quality could be affected by excessive drinking. The quantity and frequency of alcohol consumption among the late-onset drinkers were determined as well.

The investigators divided the project into four treatment modules. These modules were designed for participants to identify the components of the general and ultimately their own behavior chains that led to their drinking problems. In addition to the analysis of drinking behavior, participants were taught self-management techniques for high-risk situations, alcohol information and education, and general problem-solving skills.

The researchers found that success, as defined by participants maintaining their respective goals of alcohol consumption, was quite high among those who completed the treatment program. They found that after a 12-month follow-up period, most of the participants in their program demonstrated significant improvements in functioning as well as an increase in the size of their social networks.

Dropouts of the project had lower estimates of success and higher depression scores, and also tended to drink more alcohol than the graduates. The investigators also found that the great number of late-onset drinkers warrants age-specific treatment programs (Dupree et al., 1984).

As a component of the comprehensive Alcohol and Drug Dependence Treatment Section (ADDTS) of the Psychiatric Service at the Portland, OR, Veteran's Administration Medical Center, the ADDTS Class of '45 program offers clients evaluation, detoxification, and residential and outpatient services that employ paraprofessionals, recovering addicts, and professional staff members. This elder-specific program is available to any veteran accepted for outpatient alcoholism treatment who was on active military duty during or before 1945 (Kofoed, Tolson, Atkinson, Turner, & Toth, 1984).

The Class of '45 program offers three concurrent groups of 30 participants. Groups meet weekly for 1½

hours, specifically during daytime hours, to increase public transportation accessibility for all older participants who do not drive and prefer not to travel at night. Many clients also attend a local elder-specific AA meeting for additional support (Atkinson, 1984).

COMPARISON OF MIXED-AGE AND ELDER-SPECIFIC GROUPS:

In their Class of '45 study, Kofoed and colleagues (1987) retrospectively examined the course of outpatient alcoholism treatment by comparing the results of 24 elderly alcoholics who were mainstreamed into a typical mixed-age outpatient group with the results of 25 elderly alcoholics treated in the special geriatric peer group program.

In comparing the elder-specific Class of '45 group to the mixed-age groups at the ADDTS, Kofoed and colleagues (1987) found that the most obvious difference between these two groups was the quick development of a strong attachment among group members in the elderly peer group. Participants showed a ready acceptance of all group members, leaders, and group goals. Group members also exhibited a sense of camaraderie with each other (Kofoed et al., 1984). Overall, the researchers found that members of the elderly peer group were more compliant, remained in treatment significantly longer, and were more likely to complete their treatment programs than were elderly participants of the mixed-aged group; the process became fragmented in the mixed-age groups as older clients increased in the group-oriented program. Many older clients in the mixed-age group also reported feeling uncomfortable when outnumbered by younger clients (Kofoed et al., 1987).

The researchers noted that the major difference between elderly problem drinkers and their younger counterparts stems from the older drinkers' attitude and responsiveness to treatment strategies. After comparing the elderly peer group with the mixed-aged group, Kofoed and colleagues (1987) concluded that elderly

alcoholics respond to sociotherapeutic intervention and prefer peer groups to age-heterogeneous groups.

Therapeutic Community

In the therapeutic community, client-staff groups are established to discuss clients' problems. Members of this community are offered greater autonomy to make decisions about their own needs. Atkinson (1984) notes that therapeutic community intervention has been found to be effective in reducing problem drinking and other behavior disorders in both the community and institutional settings.

Zimberg (1971) reports that in their study of 103 elderly alcoholics in treatment, Rosin and Glatt found that the most beneficial services provided for this group were those that included interaction with other people, such as environmental manipulation, medical services, day hospital care, and home visits by staff or good neighbors. Therefore, a schedule that includes volunteer or part-time jobs coupled with structured, interactive nonworking time would serve as a practical substitute to a work situation for recovering elderly alcoholics.

Factors in Elderly Treatment Responsiveness

After studying over 600 subjects for almost 40 years, Vaillant (1983) identified factors associated with recovery from alcoholism. Two factors that were strongly operative in the Class of '45 project were the increased sources of unconditionally offered support and a source of renewed hope and self-esteem (Vaillant, 1983). Other factors included a dependence on a nonchemical substitute for alcohol, which is a strong component of the SAS recovery group, as well as the use of external, ritual reminders that even one drink can lead to pain and relapse.

Felker (1988) explains that the community-based Elderly Recovery Group in Wisconsin incorporates all

four factors of recovery. The group offers a nonchemical substitute for alcohol through the continual concern and active problem solving efforts offered by each member and the group's professionals. Through group readings and discussions of each other's infrequent setbacks and relapses, members receive external, ritual reminders of the dangers involved in taking even one drink. The program also offers increased sources of unconditional social support and a source of renewed hope and self-esteem (Felker, 1988). Similar to the Class of '45 program, the Elderly Recovery Group offers nonjudgmental social support to renew members' faith, hope, and self-esteem (Felker, 1988).

The Elderly Recovery Group was developed in response to the need for an alcohol and substance abuse/dependence support group among the 350 older people housed in three Wisconsin senior citizens' complexes. After conducting a community assessment of this population, two health professionals who had been working with this community realized the high prevalence of alcoholism, which was often accompanied by abuse of prescription medications within this residential elderly population (Felker, 1988).

Having decided to develop the group, they succeeded in acquiring the appropriate staff through a joint effort between various health care agencies and well-developed alcohol treatment programs (Felker, 1988). Although many residents of the senior citizens' complexes in Wisconsin had repeatedly been to the County Alcohol Detoxification Unit, Felker (1988) notes that many problem drinkers did not perceive the seriousness of their conditions or believe that their health was actually in danger.

Six months prior to initiating the group, the trial stage was implemented in the form of a one-on-one interaction between the professional staff and apartment residents. This trial period was quite instrumental in the decision-making stage, because the trust that developed between the apartment residents and the health professionals encouraged these geriatric alcoholics to agree to

participate in the developing groups. Having made the decision to join the program, the residents ultimately adopted the group concept (Felker, 1988).

Felker states that because group sessions were held in community rooms within the apartment complexes, many members felt stigmatized by their nondrinking neighbors. In response to this, **the group incorporated role-playing strategies to develop methods of responding to neighbors' remarks.** He further notes that as members practiced the skill of assertiveness, they became better able to handle the stresses associated with the confrontations with their neighbors.

Although the group had very few rules, it did have some norms, or common beliefs, about the way members were expected to behave. Because trust is a major determinant of a group's success (Johnson & Johnson, 1987), **strict respect for members' confidentiality** outside of the meeting was stressed (Felker, 1988).

CONTINUED CARE SUPPORT GROUP:

Similar to the Elderly Recovery Group in Wisconsin, the **Helping Hands Program** at the Alcoholism Treatment and Education Center (ATEC) in Long Beach, CA, is a continuing care support group, free of charge and open to any elderly alcoholic. Most group members are referred from the inpatient Alcoholism Treatment program at Memorial Hospital Medical Center (Glassock, 1979).

The clearly defined goals of the Helping Hands group include **helping older, recovering alcoholics develop a positive, creative sobriety; establishing and maintaining a continuing life support system; and developing and expanding the channels between the Helping Hands program and the community senior services agencies, alcohol rehabilitation facilities, and other community resources** (Glassock, 1979).

The Helping Hands program is comprised of two phases. **Phase I addresses the physical withdrawal of alcohol.** Members are sent to a 3-week inpatient detoxification program at Memorial Hospital's ATEC unit. Family and close friends or neighbors are encouraged to

become involved in the alcoholic's treatment program early in the recovery process. Emphasis is placed on the **development of self-responsibility and autonomy**, which is the premise of a followup support system (Glassock, 1979).

During Phase II, the social/psychological evaluation period of the Helping Hands program, the patient's environment is assessed with the main focus being the patient's hospital discharge. The evaluating health specialist looks for **strengths, interests, and other significant factors that can be restored** and directed to contribute to that patient's recovery (Glassock, 1979).

Several group participants volunteer to reach out to newcomers by telephoning them, offering peer counseling, and following up on their progress. Other members have established additional AA and Helping Hands groups in communities that needed these support tools (Glassock, 1979).

A special daily therapy group for the older discharged alcoholic also addresses age-related issues as well as problem drinking (Glassock, 1979). Upon leaving the ATEC inpatient program, a discharge plan resource network refers patients to AA meetings and other support systems. Glassock noted that some elderly problem drinkers use the Helping Hands group as a stepping stone for entry into other programs like AA.

Conclusion

Alcoholism remains a complex problem faced by all age groups. The elderly alcoholic is particularly subject to underdetection and undertreatment, despite the notable success rate of multiple treatment modalities. In fact, the elderly may have even better treatment responses than their younger counterparts, especially if treated in peer groups and when social and medical factors contributing to alcoholism are addressed. With the "graying" of America, all mental health specialists will need to become increasingly familiar with the special treatment needs of the elderly alcoholic.

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Questions Based on this Lesson

41. Which of the following is not a characteristic of early-onset alcoholics?
- A. Life-long addictive patterns with weak family affiliations
 - B. Greater psychological stability than late-onset alcoholics
 - C. Lower occupational and socioeconomic status than late-onset alcoholics
 - D. Family alcoholism is more common than in families of late-onset alcoholics
42. Which of the following statements about older populations and alcoholism is true?
- A. Because the prevalence of alcoholism in elders is well-documented, health care professionals are often quick to diagnose alcoholism.
 - B. Older alcoholics often come to treatment reluctantly, usually only at the insistence of family members.
 - C. Late-onset alcoholics have a significantly high level of problems with the police and employers.
 - D. In addition to being at an increased risk for physical disorders, elderly alcoholics report an extremely high rate of depression.
43. Which of the following does not characterize the behavioral model of treatment for alcoholism?
- A. The focus on alcoholism as a disease
 - B. Emphasis on changing the individual's daily life functions
 - C. A token-economy system of rewards through privileges
 - D. Electrical, chemical, or verbal aversion therapy
44. Which of the following evidence does not support age-specific treatment for elderly alcoholics?
- A. Older participants in the mixed-age Class of '45 group reported feeling uncomfortable when outnumbered by younger participants.
 - B. Older drinkers have different needs and generally respond to different treatment strategies than do younger drinkers.
 - C. Overall, members of the elderly same-age peer group remained in treatment longer and were more likely to complete their treatment programs than were elderly participants in the mixed-aged group.
 - D. None of the above

Directions in Mental Health Counseling

VOLUME 3 • LESSON 12

Women at Risk for Committing Suicide

Lucy Davidson, MD

Dr. Davidson, who maintains a private practice in Atlanta, GA,
is Clinical Associate Professor of Psychiatry at the Emory University School of Medicine.

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Editor's Note

The more we understand the risk factors for suicidal behavior, the better able we will be to successfully intervene. Although some of the motivations and characteristics that increase the risk of suicide are similar for men and women, certain features differentiate risk on a gender basis.

The completed suicide rate is nearly four times higher for men than women, although attempted suicide is believed to be about three times more common among women than men. Firearms are the most common methods of completed suicide for women. Less violent methods such as self-poisoning are more common in women attempting suicide; such attempts are often considered to be "cries for help."

Risk factors include physical and/or sexual abuse. Major depression is a more common precipitant among women, whereas personality disorders are the main precipitant for men. Borderline personality disorder carries a particularly high risk for self-destructive behavior in women. In a unique prospective study of gifted persons, suicide rates were extraordinarily high, and fifty percent of the women who committed suicide had lost their father through death or desertion before age 20.

A connection between phases in the menstrual cycle and suicide risk has not been demonstrated. Pregnant women do have a lower risk, but, as in every case, clues that point to suicide should never be overlooked; *in every case, the empathic, nonjudgmental inquiry into the details of suicidal thoughts or plans must be carried out* to provide proper assessment and set the stage for prevention.

Introduction

Nearly 29,000 Americans commit suicide annually, making suicide the eighth leading cause of death. Women at risk for suicide comprise a smaller subset of this population even though women are overrepresented among psychiatric patients. **Completed suicide rates differ substantially between men and women—4.8 per 100,000 population for women and 19.9 for men** (National Center for Health Statistics, 1992). Understanding gender-specific differences in the presentation of suicidal women, risk factors, and treatment is helpful in reducing this loss of life.

Epidemiology

Suicide rates for white females are twice that of black and other-race females. Among women, the youngest and oldest age groups have the lowest suicide rates, while those in mid-life have the highest rates. However, rates for younger women have increased since 1950, and rates for older women have decreased. Married women have the lowest suicide rates while divorced and widowed women have the highest. Firearms are the most common method of suicide among women, followed by poisoning (including intentional drug overdose) and gas.

Unlike completed suicides, suicide attempts are not reported nationally. Therefore, our data are derived from smaller studies with limited generalizability. **Suicide attempts are believed to be at least 8–10 times as frequent as completed suicide.** The male-female ratio is reversed in suicide attempts, with women believed to attempt suicide three times as often as men. Women who attempt suicide are a younger population than those who complete suicide. Poisoning is the most common method of suicide attempt.

Over the past 40 years, suicide rates among adolescents 15–19 years of age have quadrupled. The Centers for Disease Control have assessed the range of suicide

attempt behaviors among this high school population through the Youth Risk Behavior Survey. This self-report survey asked students whether they had ever seriously thought about attempting suicide during the past year, if they had made a specific plan, how many actual suicide attempts they had made, and whether any attempts resulted in treatment by a doctor or nurse. **Female students were significantly more likely than male students to report serious suicidal ideation (33.9% versus 20.5%), having made a suicide plan (20.2% versus 12.3%), or having attempted suicide (10.3% versus 6.2%) during the 12 months.** In addition, more female than male students had made attempts requiring medical attention (Centers for Disease Control, 1991). These attempts among female students represent serious health problems and serve as markers for potential substance abuse, depressive and adjustment disorders, and increased risk of completed suicide.

Risk Factors

PHYSICAL ABUSE:

Exposure to child abuse (including sexual abuse) or neglect increases the likelihood of adolescent suicidal behavior (Deykin, Albot, & McNamarra, 1985). Violence as a means of coping with stress may become a learned response, easily redirected towards oneself. The low self-esteem observed among abused and neglected children may also predispose to suicidal behaviors. Similar dynamics may be operative among adult female victims of battering who are also at increased risk for suicide attempts (Stephens, 1985).

LESBIANS AND GAYS:

Lesbians and gays are another group more likely to have attempted suicide than demographically comparable heterosexuals. However, situational precipitants to attempted suicide differ between lesbians and gay men. **The context of a suicide attempt among homosexual**

men is often an *intrapersonal* conflict or conflict with family members over incipient homosexual identity. Among lesbians, a more common context of attempted suicide is a break-up of the relationship with a significant other (Harry, 1991).

SOCIOCULTURAL FACTORS:

Sociocultural factors may account for greater help-seeking behaviors among women, including **suicide attempts initiated as a "cry for help."** More women who complete suicide choose less immediately lethal methods (such as cutting, drowning, or self-poisoning) than men. Although gunshot is the most frequently used method of suicide among women and men, proportionally fewer women choose the more immediately lethal methods of gunshot, hanging, or jumping. Some authors conclude that fewer women intend their suicidal behaviors to result in death (Rich, Ricketts, Foculer, et al., 1988). **The lower incidence of substance abuse among women may also contribute to their lower suicide rates.**

Presumed greater help-seeking behavior among women, however, does not mean that the potentially suicidal woman will seek help consciously or directly for her suicidal intent. She may present to her family physician with headaches and insomnia after being left by her husband or boyfriend. She may come to the emergency room with injuries that she reports from "a fall," although these injuries are distributed in a body pattern consistent with battering. She may be someone who has not shown up at her children's school functions recently and who has dropped out of her tennis league and consults her minister because she feels guilty. **Careful assessment of suicidal intent allows for interventions that may preclude its enactment in an overt suicide attempt.**

MENTAL ILLNESS:

Mental illnesses predisposing to suicide such as depression, schizophrenia, and alcoholism are ex-

pressed differently in women and men. Crying is a good indicator of depressed mood in women, but not in men. Conversely, depressed women show fewer interpersonal problems than depressed men (Ross & Mirowsky, 1984). Gender differences among schizophrenic persons include a later age of onset in women (illness beginning in the late 20s or early 30s for women versus late teens to early 20s for men). The women were also more likely to be living with a partner and have more favorable social functioning (Test, Burke, & Wallisch, 1990). The later onset of schizophrenic illness in women may be a protective factor against suicide, allowing developmental consolidation of gender identity and greater social and vocational skills acquisition. **Suicide attempts represent a more common path to treatment among alcoholic women than alcoholic men. Suicide attempts are even more prevalent among those women addicted to both narcotics and alcohol (Bissell & Skorina, 1987).** Suicide occurs relatively early in the course of depressive illness, while it is a later outcome of alcoholism.

Goldney's study (1981) of suicide attempts by overdose among young women demonstrated characteristics of those women whose attempts represented a serious threat to life. They were more likely to be unmarried, use little alcohol, have recently contacted a therapist, and report strong feelings of hopelessness. They were likely to have ingested antidepressant medication, indicating treatment for depressive illness, since this type of prescription medication is not a drug of street abuse.

Major depression is a common precipitant to suicide and is more prevalent among women than men. In the Iowa Record-Linkage Study, a follow-up of psychiatric patients after hospital discharge showed that women who committed suicide took their lives sooner after discharge than men. Over half the suicides among this group of women occurred within the first 6 months after discharge. Affective disorder was the most common

diagnosis among the women who committed suicide and an increased number of suicides also occurred among those diagnosed with schizophrenia or substance abuse. **Men, but not women, diagnosed with personality disorders also exceeded the expected number of suicides** (Black, Warrack, & Winokur, 1985).

Depression also has a differential expression in suicide pacts or murder-suicides among male/female couples. **In suicide pacts between a man and a woman, the instigator is usually the man and the woman is the cooperator.** The instigator may exert a great deal of pressure on the cooperator to comply. She may be motivated to comply because she is bonded in an intensely ambivalent relationship and is overwhelmed by guilty wishes to be rid of her partner. The instigator is more likely to die in the attempt, to have been depressed, and to have a history of suicidal behavior. **The cooperator is more likely to survive,** not to have carried a psychiatric diagnosis, and not to have previously been suicidal (Rosenbaum, 1983). **Perpetrators of murder-suicide are depressed (75%) men (95%) in contrast to nearly equal gender distribution among perpetrators of domestic homicide** (Rosenbaum, 1990).

Female inpatients with borderline personality disorder comprise a group at high risk for self-destructive behaviors with and without conscious suicidal intent. Eighty percent are reported to have engaged in self-injury *without* suicidal intent, such as self-cutting or self-burning. Lethality of self-destructive behavior correlates highly with the woman's number of previous suicide attempts, thus contradicting the common assumption that multiple suicide attempts represent "gestures" with low suicidal intent. Intent and lethality of self-destructive behavior among these borderline women was also correlated with concurrent eating disorder, a history of psychotic features, and a family history of affective or substance abuse disorder (Shearer, Peters, Quaytman, et al., 1988).

PROSPECTIVE RISK STUDIES:

Prospective, controlled studies of completed suicide are rare. This type of study, however, can help depict the potential suicide through data collected before death and unbiased by retrospective interviewing. Data from the Terman Genetic Studies of Genius (I.Q. above 135) provided information collected longitudinally over 60 years on 1558 women and men. Data from this enormous study were abstracted to compare women who committed suicide, age-matched controls who died of natural causes, and living controls.

Eight of the 672 women committed suicide for a **female suicide rate of 1190 per 100,000 compared with a male rate of 2336 per 100,000.** Both male and female suicide rates among these gifted persons are extraordinarily high; the gifted women's rate was nearly 250 times that of the general population of women. The gifted women who committed suicide showed a greater number of the following risk factors, although no one risk factor was distinguishing: **previous suicide attempts, anxiety, conspicuous instability, depression, and alcohol abuse.** These risk factors had also identified male suicides in the same population. Fifty percent of the women who committed suicide had lost their father through death or desertion before age 20 compared with 20% of the entire sample. Earlier mother loss, though, was not correlated with suicide. Self-reports of temperament characterized the women who committed suicide as more impulsive and emotional, more moody, less happy, and less self-confident. Chronic stress in the family of origin, parental conflict, and the woman's relationship with her parents did *not* differentiate the suicides from controls (Tomlinson-Keasey, Warren & Elliott, 1986; Warren & Tomlinson-Keasey, 1987).

Since Durkheim's pioneering explorations of sociological variables and suicide, correlates have been sought for the uneven distribution of completed suicides. Sociological efforts to explain the increasing rates of female

suicide in some cultures (or a lessening of the male-female ratio of suicide) have emphasized increases in women's work force participation. **This variable as a proxy for many aspects of cultural modernization correlates higher suicide rates with the overall increased socioeconomic status of women.** Economic cycles in developed countries correlate with shorter-term fluctuations in suicide rates. **Unemployment, rather than economic recession itself, is associated with the higher suicide rates among both women and men during economic downturns** (Hassan & Tan, 1989; Pritchard, 1990; Souetre, Wehr, Douillet, et al., 1990).

Chronically Suicidal Women

Some clients repeatedly present in suicidal crises. Litman (1989) estimates that 20%-25% of such chronically suicidal persons will eventually complete suicide, yet the odds of surviving any particular year are 95%. Crisis intervention strategies alone are ineffective efforts because the suicidal behaviors are expressions of a self-destructive lifestyle. **Transforming this self-destructive life pattern is a long-term process; working as a treatment team may forestall professional burnout** (Litman, 1989). Flexible combinations of medications and psychotherapeutic approaches involve **limiting the secondary gains** of suicidal behavior and realistically **limiting the therapist's role in changing the client's behavior.** The therapist may feel pushed into advocating life so unambivalently that the client then unambivalently pursues death. Acknowledging the client's choice in maintaining life involves tolerating some short-term risks in the service of more gradual, long-term benefits.

Gynecologic and Obstetrical Effects

The relationship between suicidal behaviors and menstrual phase has been explored with varying degrees of

polemic, science, and calumny. A number of studies have been flawed by compressing cycle length to a hypothetically standard 28 days, which then artificially elevates reported rates of suicidal behaviors during the first few days of the next "cycle." **A meta-analysis of reliable findings for attempted suicides shows a decrease in attempted suicide during days 15-21 of the cycle.** Circulating levels of estrogen and progesterone are high during this time, but particular variations in mood states have *not* been reported for this interval. Thus, the data support some hormonal basis for the variation in suicide attempts, rather than an observable psychological/mood fluctuation (Lester, 1990).

Endometrial samples at autopsy have been examined to study possible relationships between menstrual phase and death among reproductive age women. Thus, phases of the menstrual cycle could be reliably determined histologically, rather than by any form of calendar report. **Deaths by suicide, accident, homicide, and natural causes were each distributed evenly over phases of the menstrual cycle** (Vanezis, 1990).

Women during pregnancy and the puerperium have a low risk of suicide, despite this being a time of stress, dynamic transition, and physical/hormonal disruption. Pregnant women are estimated to have one-twentieth the expected suicide rate. **Although pregnant teenagers are at lower risk than nonpregnant female teens, their suicide risk is five times that of pregnant women as a whole.** Most suicides during pregnancy occur during the second trimester and postpartum suicides occur most often during the first month after delivery. The first month after delivery also corresponds with the peak incidence of postpartum psychosis. Child-related concerns are posited to account for the protective effects of pregnancy in reducing suicide. These concerns include feeling that suicide would harm the child or other children, that it would be unfair to abandon children to someone else's care, and the positive desire to watch

children grow. Thus, pregnant teens, especially those who may be experiencing an unwanted pregnancy, represent a high risk subgroup for suicide within a low risk population (Appleby, 1991; Harry, 1991).

Case Vignette

A psychological evaluation was initiated by Ms. B's employer following a month of medical disability leave during which she had been treated for depression by her family physician. Upon examination, her chief complaint was, "I'm tired—I don't feeling like trying no more."

She described increasing unhappiness in her marriage culminating in her decision to get a divorce. **Her husband had moved out 6 months previously, and had subsequently attempted suicide by carbon monoxide poisoning.** She felt that the separation and his suicide attempt estranged her from both families' support, and that both families saw her as at fault for these events; she alternately felt unjustly blamed and guilty. **Isolated from both his and her families, she was increasingly unable to manage without their support.** She reported that **her husband had been physically abusive in the past and had threatened her over the divorce:** "He said if I got the kids, I wouldn't live to enjoy them. I asked why and he said he'd kill me."

She described her husband as an impulsive spender whom she felt helpless to stop. The couple had accrued sizable debts, and her automobile had been repossessed. She had gone to bed one night wondering, "How come?" and woke up the next morning sick, dizzy, and throwing up. Her family physician initiated antidepressant pharmacotherapy. She had recently driven to her county mental health clinic and parked, but could not go in, fearing that the clinicians in the community would talk about her.

During the interview, Ms. B expressed extreme concern about confidentiality and wondered if a tape

recorder was hidden in the room. Her speech was voluble as she shifted from present to past events without expressing verbal indicators of any chronology. **Her affect was labile, alternating guardedness with a rather desperate, no-holds-barred openness. Her mood was dysphoric and hopeless.** She described feeling very irritable, and lacked energy and concentration: "I don't do nothing." She described trouble with daily living tasks and child care. She exhibited no social or sexual interest, and had made up excuses to **avoid people.** She reported that her **personal hygiene had deteriorated** and that she had lost 50 pounds over the previous 6 months.

Ms. B believed that she was going crazy and revealed that she had been experiencing **auditory and visual hallucinations for 2 years.** Her three principal repetitive hallucinations were: (1) Picturing her sons in their caskets and trying to figure out what happened; (2) struggling unsuccessfully to straighten the jewelry on her dead grandmother; and (3) trying unsuccessfully to keep her other dead grandmother's feet warm. **Unable to sleep at night,** she would stay awake ruminating on the meaning of these hallucinations.

Although **Ms. B had a breast mass** of increasing size, she had not pursued recommended evaluation, despite the fact that her mother had had breast cancer. She remarked, **"If it's cancer, I can get out of life the natural way."** Regarding her husband's abusiveness, she remarked with little anxiety: "If he would hit me, maybe it would kill me." **She had thought often of suicide,** feeling that she could not bear the pressure she was under. She debated running her car off the interstate; also, she owned a gun and had sat holding it, debating whether to shoot herself. She denied any homicidal thoughts.

Ms. B's doctor had recognized that she was very depressed. He had inquired about suicidal feelings, and she had replied that she thought of it but "wouldn't do it because of my kids." They had not discussed it further because he thought that it would be counterproductive to dwell on it.

ANALYSIS:

Tragically, most women who commit suicide consult a health care professional in the week before death (Murphy, 1975). By not inquiring further, the physician lacked information upon which to make his own assessment of Ms. B's suicidal potential; instead, he accepted her "rational" defense against suicide (her children's welfare) as sufficient.

Caregivers may be blind to seriously lethal intent in women through cultural biases or other assumptions that women are not violent or impulsive. A remarkable report in *Obstetrics and Gynecology* describes self-inflicted gunshot wounds to the gravid uterus as abortion attempts without any consideration of suicidal intent. Buchsbaum and Staples (1985) noted that these patients were surgically managed for traumatic termination of pregnancy with no mention of mental health consultation or inquiry into their mental state!

Events preceding self-inflicted gunshot wounds are often related to substance abuse and interpersonal conflict. The lethality of the attempt is not necessarily greater with longer planning, because impulsive actions with guns are so readily fatal (Peterson, Peterson, O'Shanick, et al., 1985). Few victims leave suicide notes and many survivors will deny suicidal intent *post hoc*. One survivor of a self-inflicted gunshot wound to the head who did leave a suicide note later denied the note's relevance, insisting that the injury was accidental (Conn, Rudnick, & Lion, 1984). Mental health professionals, then, must be prepared to consider suicidal intent even in injuries where self-destructive motive is vehemently disclaimed, and make a thoughtful determination of suicide risk based on many types of data.

When the interviewer proceeds in an empathic, nonjudgmental way, the client is more likely to be able

to confide details of suicidal thoughts or plans. This approach provides data for clinical judgment instead of asking the client for a summary verdict of suicidal potential. Ms. B's conclusion that she would not commit suicide radically misrepresents her actual risk. When careful inquiry progressed from general questioning about how bad she felt to questions about hopelessness, wishing to be dead, wishing to harm herself, and details of plans and opportunities for killing herself, Ms. B displayed her lethal intent.

To be treated as an outpatient necessitates certain factors, including evidence of good impulse control, absence of psychosis or intoxication, absence of a specific plan and easily accessible lethal means, availability of social supports, and ability to establish rapport with the treating physician. Ms. B, however, evidenced a formal thought disorder, was without social or family supports, and had rehearsed suicide with her gun. Paranoia severely strained her capacity to collaborate in therapy. It was not unlikely that Ms. B might resolve her concerns about child custody and the hallucinatory puzzle of her sons in their caskets by shooting them and herself. Aggressive management of Ms. B's psychopathologic disorders in a safe environment with constant observation was imperative.

Conclusion

The therapist's appreciation of risk factors for suicide can promote more comprehensive interviewing. This type of data should be integrated with information from the mental status exam and exploration of the psychodynamic meaning of suicidal behavior for each client. We can then be more discriminating when assessing the appropriateness of potential interventions for suicidal women.

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Questions Based On This Lesson

45. Which of the following precipitating factors is cited as a common trigger for suicide among lesbians?
- A. Intrapersonal conflict
 - B. Conflict with family members over incipient homosexual identity
 - C. A diagnosis of borderline personality disorder
 - D. The break-up of a relationship with a significant other
46. Prospective studies of completed suicides have demonstrated:
- A. That alcohol abuse, anxiety, or previous suicide attempts were much higher risk factors for suicide among women than men
 - B. An extraordinarily high suicide rate among gifted men and women with high I.Q. (above 135)
 - C. That 50% of women who committed suicide had lost their mother through death or desertion before age 20
 - D. Chronic stress in family of origin clearly differentiated suicide completers from controls
47. Which of the following statements is correct?
- A. Unemployment is associated with the higher suicide rates among both men and women
 - B. Female inpatients with diagnosed personality disorder do not represent a high-risk group for suicide
 - C. Gender differences among schizophrenic persons include an earlier age of onset in women as compared with men
 - D. In the case example described by the author, Ms. B was successfully managed with once-a-week psychotherapeutic support and lithium therapy
48. In suicide pacts between male/female couples:
- A. The woman is usually the instigator
 - B. The cooperator is less likely to survive than the instigator
 - C. The instigator is not likely to have been depressed
 - D. The instigator is likely to have had a history of suicidal behavior

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